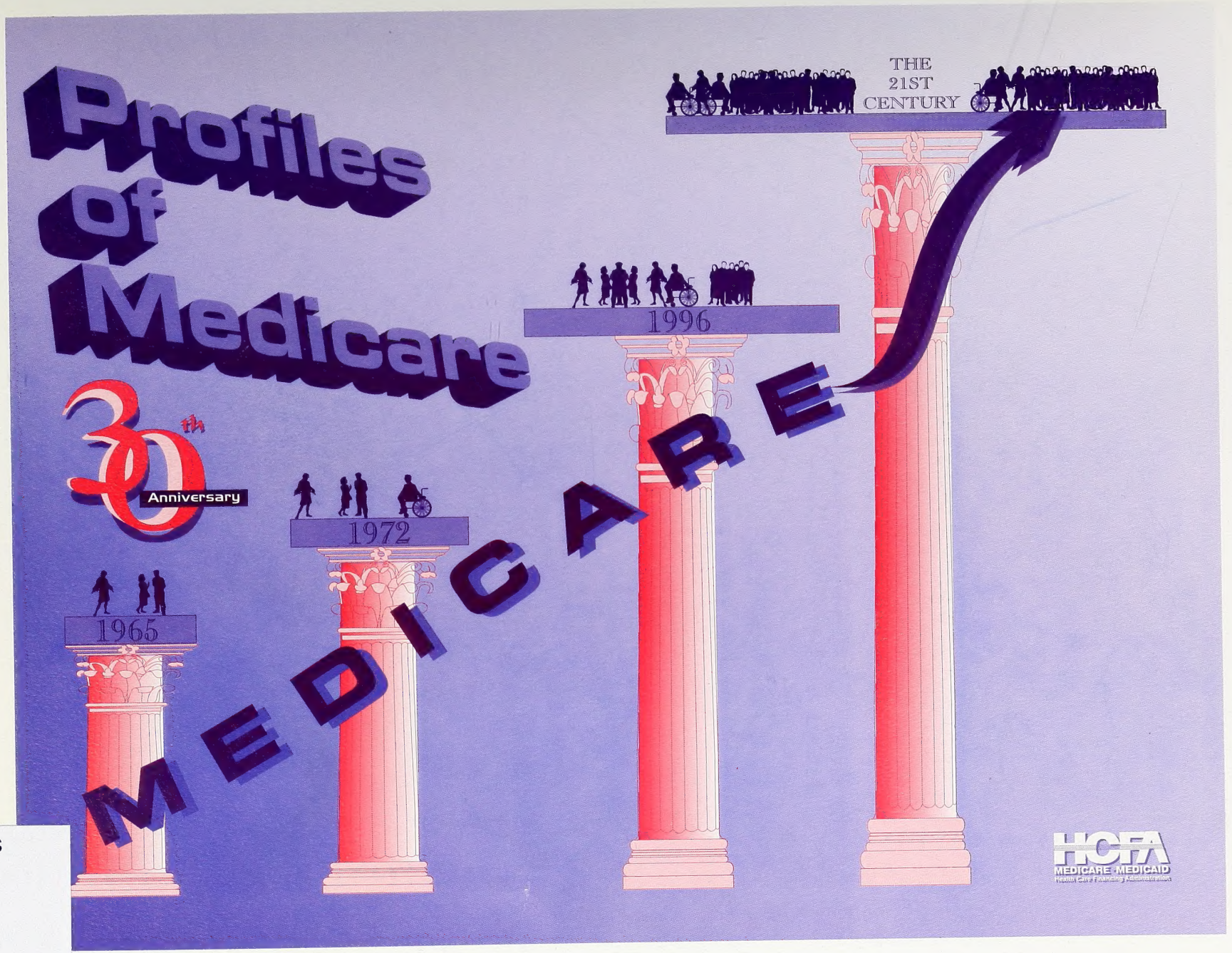

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Medical care will free millions from their miseries. It will signal a deep and lasting change in the American way of life. It will take its place beside Social Security and together they will form the twin pillars of protection upon which all our people can safely build their lives and their hopes.

- President Lyndon B. Johnson in June, 1966, just before the implementation of the Medicare program, speaking to the National Council of Senior Citizens

No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings they have so carefully put away over a lifetime so they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations.

- President Lyndon B. Johnson at the signing of the Medicare legislation in July 1965

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PREFACE

Medicare is the world's largest health insurance program, and by many measures one of the most successful. It provides access to high quality health services for more than 38 million of this nation's frailest and most disabled citizens, with an administrative cost of only 2 percent. It has pioneered in new methods of provider payment, new technologies of quality assurance, and electronic data transmission. And it has played the central role in the development of new models of health care delivery while helping to strengthen and preserve essential institutions in thousands of communities throughout the country.

For a program so large and so successful, however, Medicare is often not very well understood. Much of the public discussion of Medicare appears to be based on simple misunderstandings or misperceptions. We hope that the assembly and presentation of a few essential facts about the program and its beneficiaries will contribute to better understanding of Medicare by policy-makers, analysts, and the general public.

As we celebrate the 30th anniversary of Medicare's implementation in the midst of a rapidly changing health care system and a complex socioeconomic environment, we hope that a clearer understanding of the basic facts about Medicare will strengthen the process of adapting Medicare to meet the challenges of the future as successfully as it has met those of the past.

Bruce C. Vladeck
Administrator
Health Care Financing Administration

May, 1996

Introduction

Medicare was established to meet a critical need in society. During the past thirty years, the program has made important contributions to improvements in health status for elderly and disabled beneficiaries.

- The Medicare program was enacted in 1965 to provide health insurance coverage to the elderly. Before enactment, many of the elderly could not secure health insurance in the private marketplace because they were unable to pay the cost of private insurance premiums. The onset of serious illness could force families to go without health care services, turn to charity, or rely on family members to finance needed services. Approximately half of the elderly population did not have health insurance coverage.

- Similar reasons motivated the inclusion of the disabled in 1972, when Congress expanded Medicare to cover individuals who have been permanently and totally disabled for at least two years, and individuals diagnosed with end-stage renal disease.

- During the past thirty years, Medicare has provided the elderly and disabled with access to health services. As a consequence, Medicare has made important contributions to improvements in health status for elderly and disabled beneficiaries whose health needs are greater than those of the general population. Over the same period, the U.S. has made significant progress on some key health indicators, such as life expectancy: life expectancy at age 65 has increased nearly three years both for women (from 16.3 years in 1965 to 19.1 in 1992) and for men (from 12.9 years in 1965 to 15.5 in 1992) (Chart I-1).

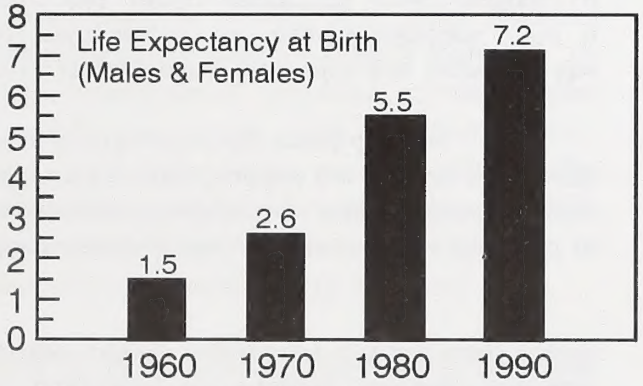
- The elderly's poverty rate has declined dramatically since Medicare was enacted, from 29% in 1966 to 12% today (Chart I-2). Improvements in Social Security and Medicare's coverage of health services were important factors in this decline.

- Today, about 97% of the elderly (more than 33 million individuals) in the U.S. are covered through Medicare. However, Medicare does not offer coverage in a number of areas important to the elderly, including outpatient prescription drugs, dental services, hearing aids, most eyeglasses, and long-term nursing home care. In addition, Medicare requires some cost-sharing in the form of deductibles, premiums, and co-insurance, so that many elderly often are faced with significant out-of-pocket costs even for covered services. To meet these needs, the majority of aged Medicare beneficiaries have supplemental insurance, either by purchasing it themselves, through their former employers, or publicly funded through Medicaid (see Chapter Three on National Health Spending.)

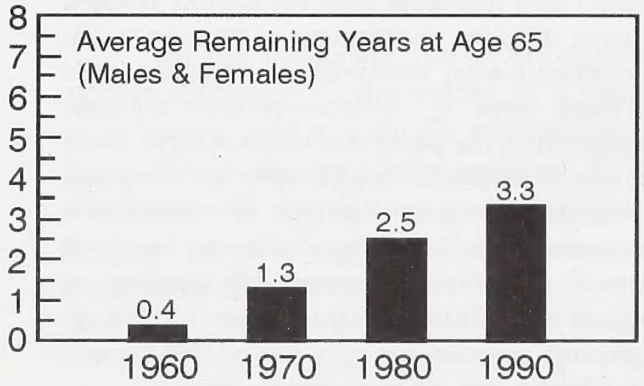
Increases Since 1950 In Life Expectancy At Birth And Average Remaining Years At Age 65, United States

Over The Past Three Decades, The U.S. Has Made Significant Progress In Increasing Life Expectancy

Increases since 1950 in...



Life expectancy at birth in 1950 was 68.3 years... in 1990 it was 75.4 years



Average remaining years at age 65 in 1950 was 13.9 years... in 1990 it was 17.2 years

Life Expectancy at Birth

Year	Males	Females
1950	65.6	71.1
1960	66.6	73.1
1970	67.1	74.7
1980	70.0	77.4
1990	71.8	78.8
1991	72.0	78.9
1992	72.3	79.1

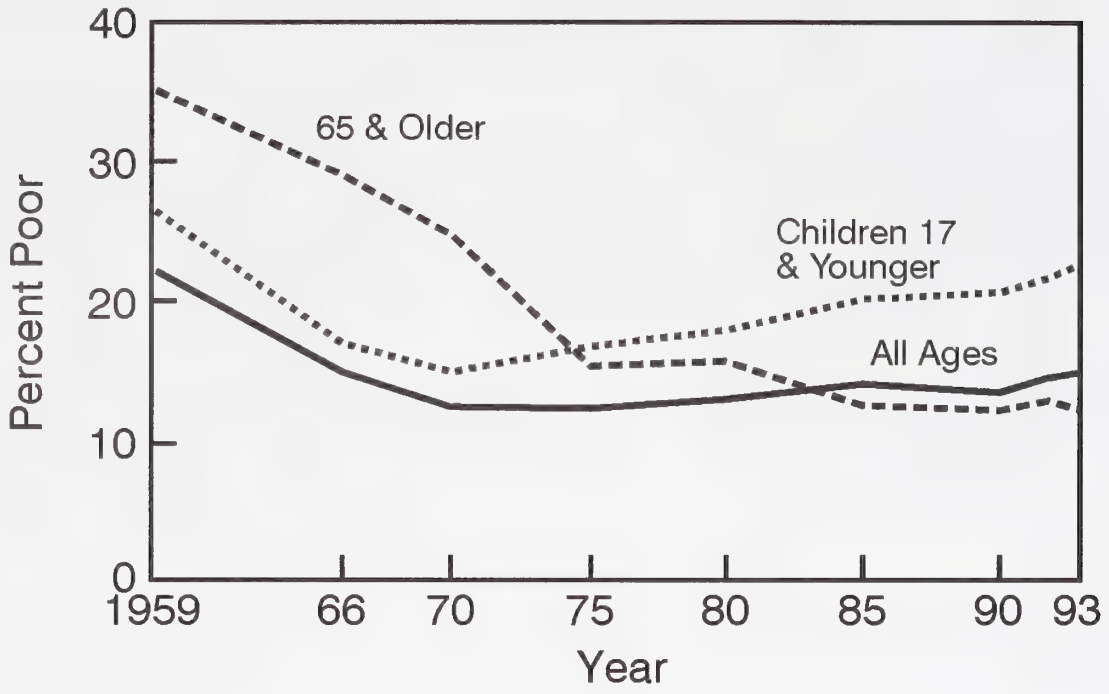
Life Expectancy at Age 65

Year	Males	Females
1950	12.8	15.0
1960	12.8	15.8
1970	13.1	17.0
1980	14.1	18.3
1990	15.1	18.9
1991	15.3	19.1
1992	15.4	19.2

Source: National Center for Health Statistics: United States, 1994 and data from the National Vital Statistics System

Poverty In The United States, 1959-1993

Improvements In Social Security And Medicare's Coverage Of Health Services Were Important Factors In The Decline Of The Elderly's Poverty Rate



Source: Social Security Administration, Annual Statistical Supplements, 1984-1985 and 1995

Profile of Medicare Beneficiaries

Today, the Medicare program provides health insurance coverage to a diverse and growing segment of the U.S. population.

- The U.S. population is aging rapidly, creating significant growth in the numbers of individuals eligible for Medicare (Chart P-1).

- Over its thirty year history, the population that is covered under the program has not only expanded in numbers, but has grown more complex in composition and health care needs. More than 19 million elderly entered the program in 1966; today, the number of enrollees has nearly doubled to approximately 38 million. Medicare's coverage of two of the most vulnerable segments of the population -- the elderly and disabled -- has increased from 9.4% of the total U.S. population in 1967 to 11.6% in 1977 and 13.6% in 1994.

- Medicare coverage is an integral part of retirement planning for the majority of the elderly; however, there are a number of particularly vulnerable subgroups within the Medicare's population who depend greatly on the security Medicare provides to meet some basic health needs, including the disabled, the "oldest" old, particularly women over the age of 85, and the poor elderly.

Enrollment in Medicare: The Medicare population is growing older and more disabled.

- An important trend to note is that the Medicare population is growing older and more disabled. The increase in the prevalence of disability is partly a result of improved trauma care, emergency medicine, and medical technology that have extended the lives of those with life-threatening or debilitating illnesses. Disabled and ESRD beneficiaries made up about 8% of the Medicare population in 1974 and have grown rapidly to 12.6% in 1996 and are projected to reach 16% by 2015. Their numbers more than doubled in the twenty-two years between 1974 and 1996, rising from 1.8 million to 4.8 million. And they are projected to increase by nearly 73%, reaching 8.3 million by 2015 (Chart P-2).

- The fastest rate of enrollment growth has been among the ESRD population. Between 1982 and 1992 the number of ESRD enrollees increased at an average annual rate of 10.1%, compared with 4% per year for all disabled persons (including ESRD) and 1.9% for aged beneficiaries (Chart P-3).

- Although growth in enrollment of the aged has followed a relatively predictable pattern, enrollment patterns for the disabled have exhibited volatile swings over the past twenty years, corresponding with changes in SSDI eligibility policy (Chart P-4).

Gender, Race, and Age of Medicare Beneficiaries

- Twenty-two percent of the Medicare population is either disabled (younger than 65 years of age) or over the age of 85. Half of the disabled population are between the ages of 35-54 (Charts P-5 & P-7).

- Approximately 10%, or 3.8 million, of the Medicare population is over the age of 85, and more than twice as many of these "oldest" old beneficiaries are women (2.7 million women compared to 1.1 million men).

- Within the elderly population, there are more women than men enrolled in Medicare, primarily because of the slightly longer life expectancy of women. However, the situation is reversed in the disabled population. This may be explained in part by the fact that there is a somewhat greater proportion of male workers who are fully insured for disability benefits (SSDI) (Chart P-6).

- The majority of the Medicare population is White. Among the elderly, African-Americans make up 8% of enrollees, Hispanics 5%, and all other races/ethnicities are 2% of enrollees. In contrast, African-Americans and Hispanics are disproportionately represented among the disabled, at 14% and 8%, respectively (Chart P-8).

Economic status of Medicare beneficiaries: Medicare coverage is particularly critical for low-income populations.

- Although the economic status of the elderly as a group has improved over the past thirty years, many elderly continue to live on very modest incomes. In 1993, 72% of elderly beneficiaries reported incomes of less than $25,000. Thirty-percent had incomes less than $10,000. Disabled beneficiaries tend to report lower incomes than elderly beneficiaries: 40.4% reported incomes of $10,000 or less (Charts P-9 & P-10).

- Many elderly Medicare beneficiaries depend on their Social Security benefits for much of their income (Chart P-11). The reliance on Social Security income is greater among single elderly individuals, and increases dramatically as individuals age. Nearly 70% of those 75 years and older rely on Social Security for over 50% of their income.

- There are substantial differences in the income distributions of Medicare beneficiaries across races: 27% of all White beneficiaries fell into the highest income quartile compared to only 6% of all African-American beneficiaries. In contrast, 19% of all White beneficiaries fell into the lowest income quartile, while 73% of all African-American beneficiaries were in the lowest income quartile (Chart P-12).

- The majority of Medicare spending is for beneficiaries with modest incomes: 38% of program spending is on behalf of those with incomes of less than $10,000; 76% of program spending is on behalf of those with incomes of less than $25,000 (Chart P-13).

- Nearly one-quarter of Medicare beneficiaries live alone, and they are disproportionately female and

poor: 51% have incomes under $10,000 (compared to 30% of all aged beneficiaries). In addition, one-quarter of those who live alone report their health as fair or poor. Medical expenses take an especially heavy toll on elderly people who live alone, increasing their poverty rate significantly (Charts P-14, P-15, P-16, P-17).[1]

Shifting demographics have important implications for Medicare spending.

- Overall, total per capita Medicare spending increases as beneficiaries age. Those over the age of 85 spend nearly twice as much as those 65-74 years of age.

- Generally across all age categories, men have higher per capita spending for inpatient, outpatient, and physician services, where as women have slightly higher spending for skilled nursing facility and home health agency services (Chart P-18).

- Female Medicare beneficiaries have greater limitations in functional status than male beneficiaries. In addition, the disparity in functional status between males and females becomes larger as they get older: 42.4% of females over age 85 have three or more limitations in activities of daily living, compared to only 27.4% of males over age 85 (Chart P-19).

- One-quarter of the elderly and more than half of the disabled rate their health as fair or poor (Chart P-20).

- Medicare per capita spending also increases as functional status declines. Those with 1-2 limitations in activities of daily living (ADL) spent 87% more than those with no ADLs; those with 3 or more ADLs spent two and a half times more than those with no ADLs.

- Again, across all categories of functional status, men have higher per capita spending for inpatient, outpatient, and physician services, whereas women have slightly higher spending for skilled nursing facility and home health agency services (Chart P-21).

Dual-eligible Medicare beneficiaries

- In 1993, there were approximately 6 million beneficiaries (about 16% of the Medicare population) who are dually-enrolled in Medicare and Medicaid at some point in the year.[2] Dually-eligible beneficiaries are Medicare beneficiaries who also qualify for Medicaid benefits because they have very low incomes and very limited assets.

- Nearly two-thirds of dually-eligible beneficiaries are women. Compared to the general Medicare population, African-Americans and Hispanics are over-represented among this group. In addition, dual-eligibles are more likely to rate their health as fair or poor (Chart P-22).

Satisfaction with care

- Medicare beneficiaries are generally satisfied with the overall quality of medical care they receive: 86% of the elderly and 80% of the disabled report being very satisfied or satisfied (Chart P-23).

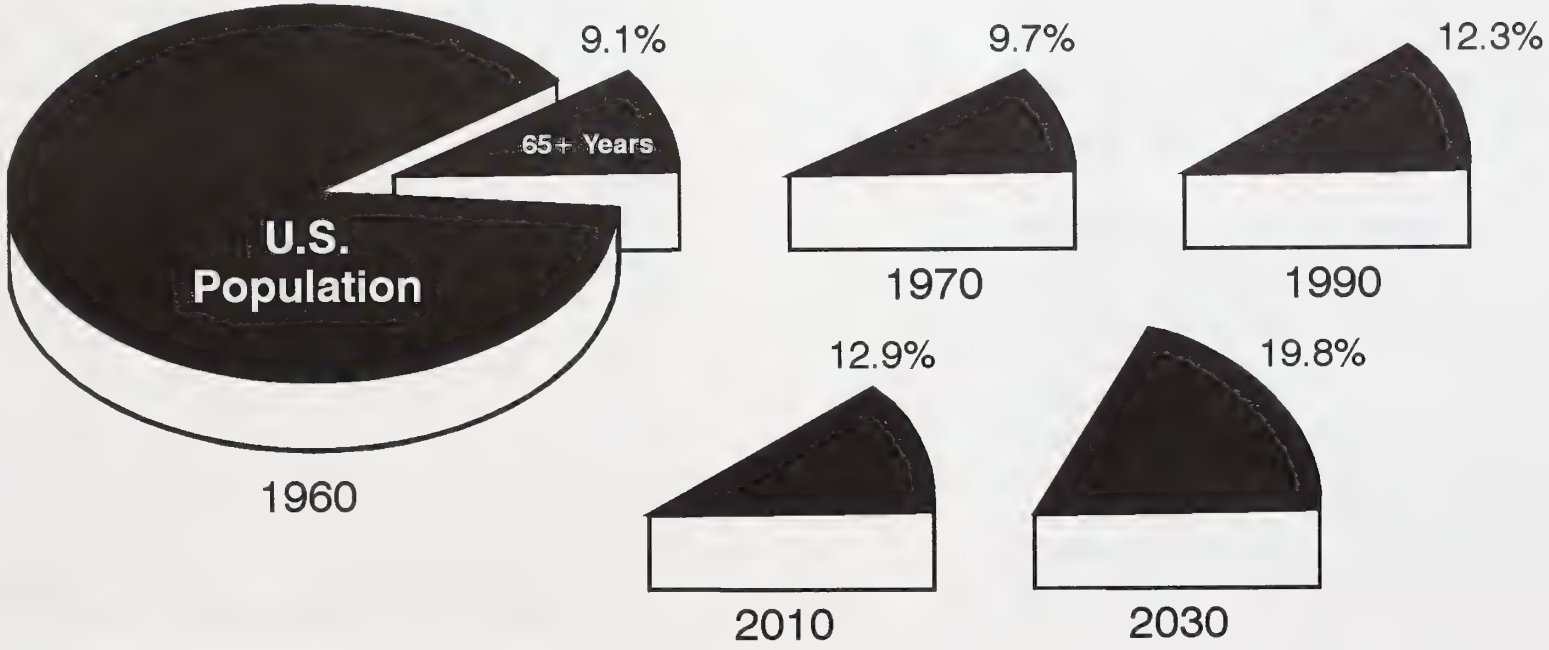
---

[1]Medicare's Poor: Filling the Gaps in Medical Coverage for Low-Income Elderly Americans, A Report of the Commonwealth Fund Commission on Elderly People Living Alone, 1987.

[2]Dual-eligibles are defined here as individuals who have been enrolled in both Medicare and Medicaid at some point in the year. The MCBS data cannot distinguish between QMBs, SLMBs, and those entitled to full Medicaid benefits.

The Aging Of The U.S. Population

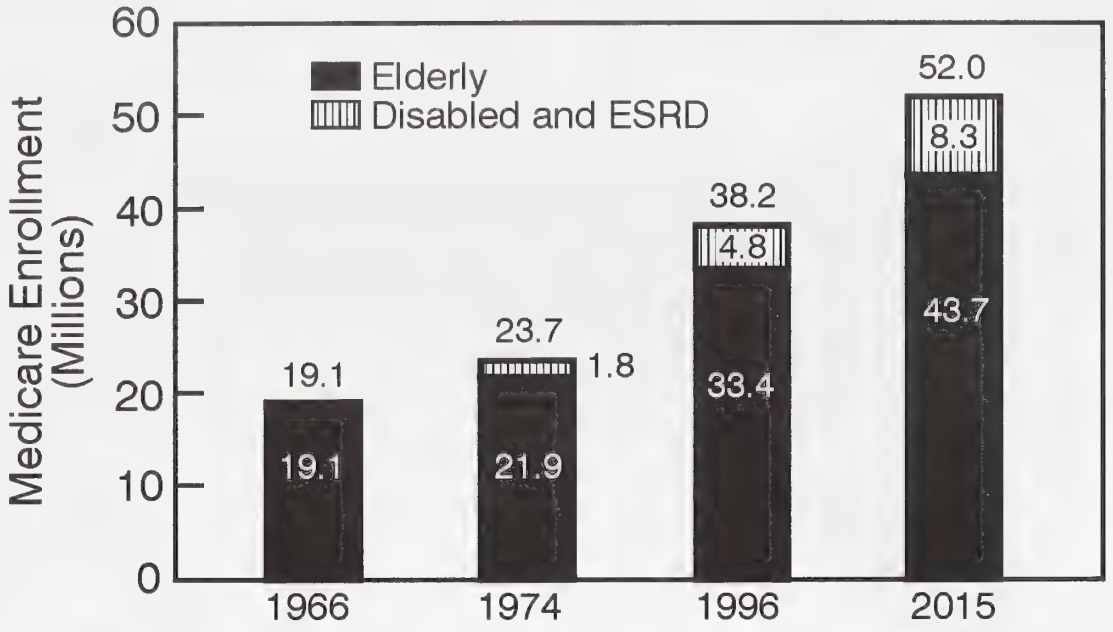
The U.S. Population Is Aging Rapidly, Creating Significant Growth In The Number Of Individuals Eligible For Medicare



Source: 1995 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Fund

Medicare Enrollment: Elderly, Disabled And ESRD, 1966-2015

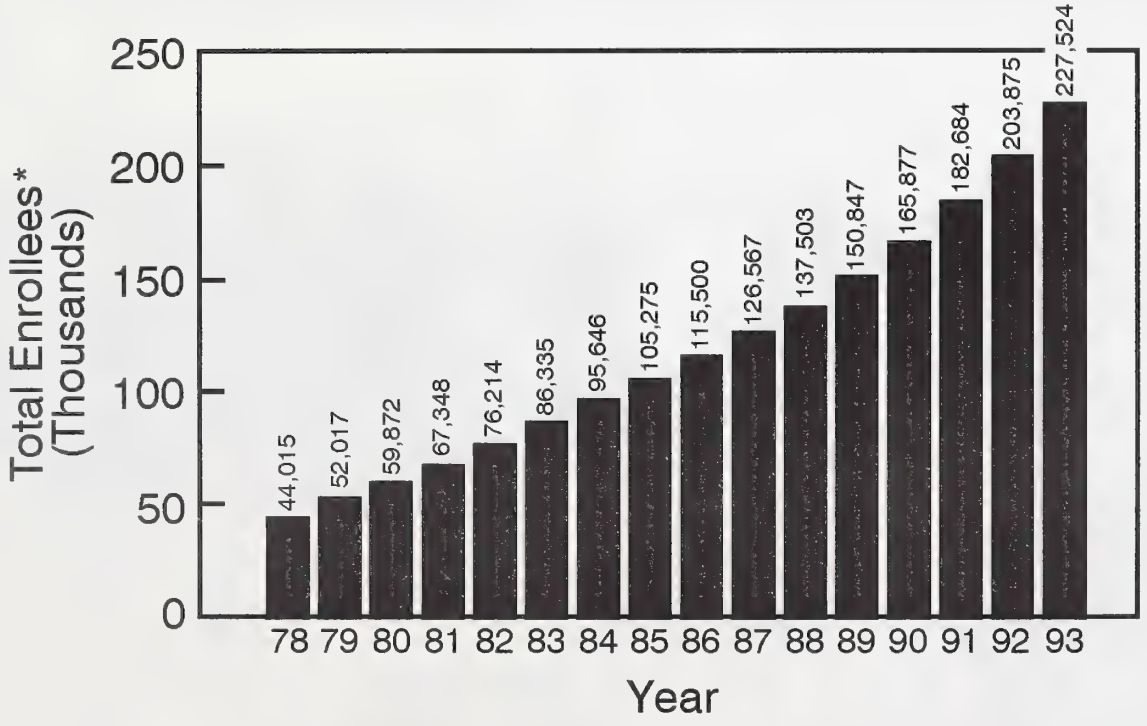
The Medicare Population is Growing Older And More Disabled



Source: HCFA/Office of the Actuary; Office of Medicare and Medicaid Cost Estimates, 1996

Growth In ESRD Enrollment, 1978-1993

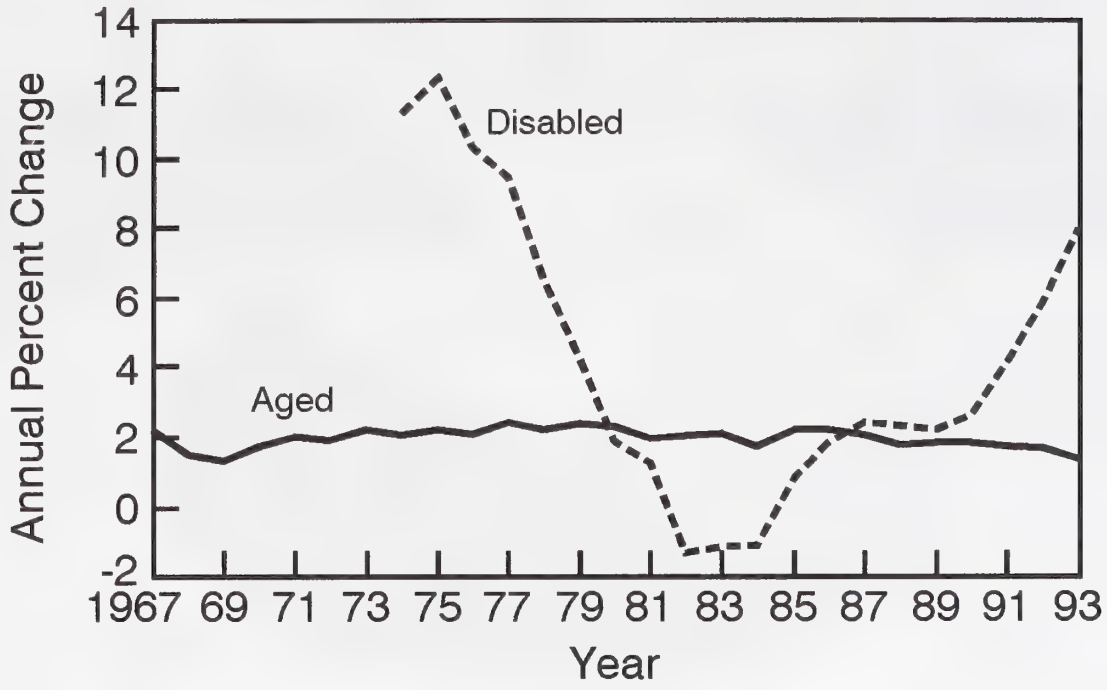
The Fastest Rate Of Enrollment Growth Has Been Among The ESRD Population



*Note; includes both elderly and non-elderly beneficiaries ESRD
Source: HCFA/Bureau of Data Management & Strategy: data from the program Management and Medical Information System

Annual Percent Change In Number Of Medicare Aged And Disabled Enrollees, 1967-1993

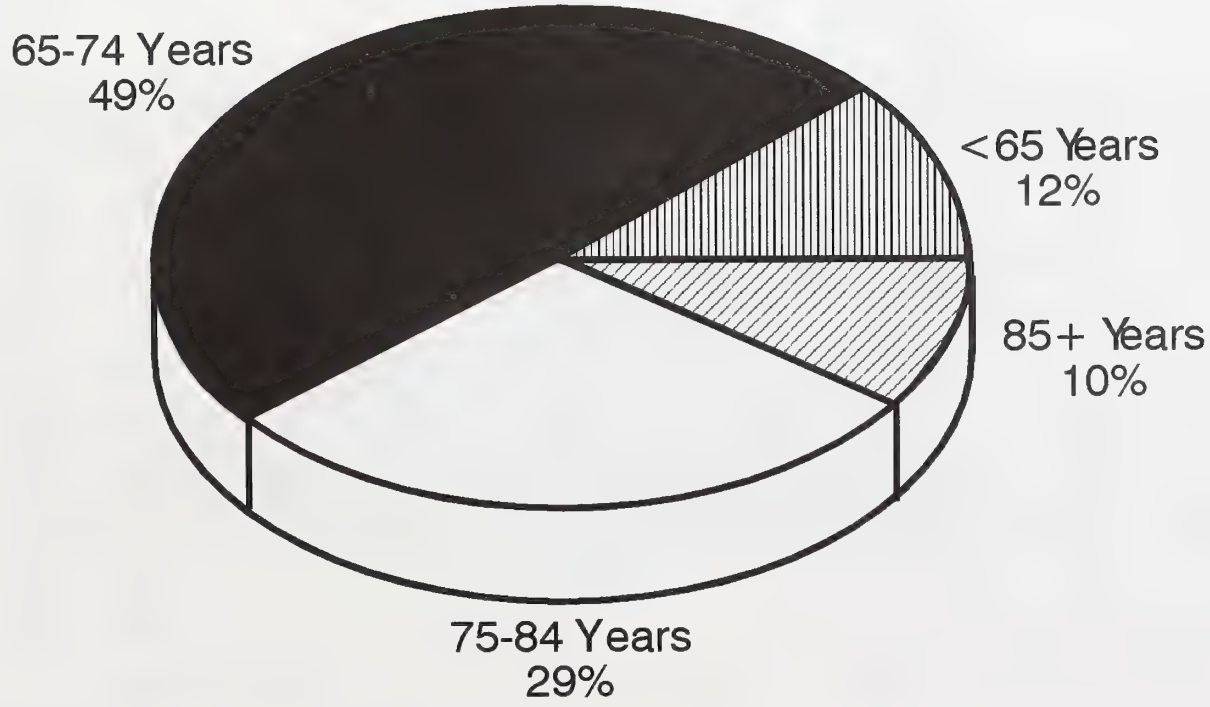
Changes In SSDI Eligibility Policy For The Disabled Have Resulted In Volatile Enrollment Trends



Source: HCFA/Bureau of Data Management & Strategy

The Composition Of The Medicare Population, 1995

22% Of Beneficiaries Are Disabled Or Over Age 85



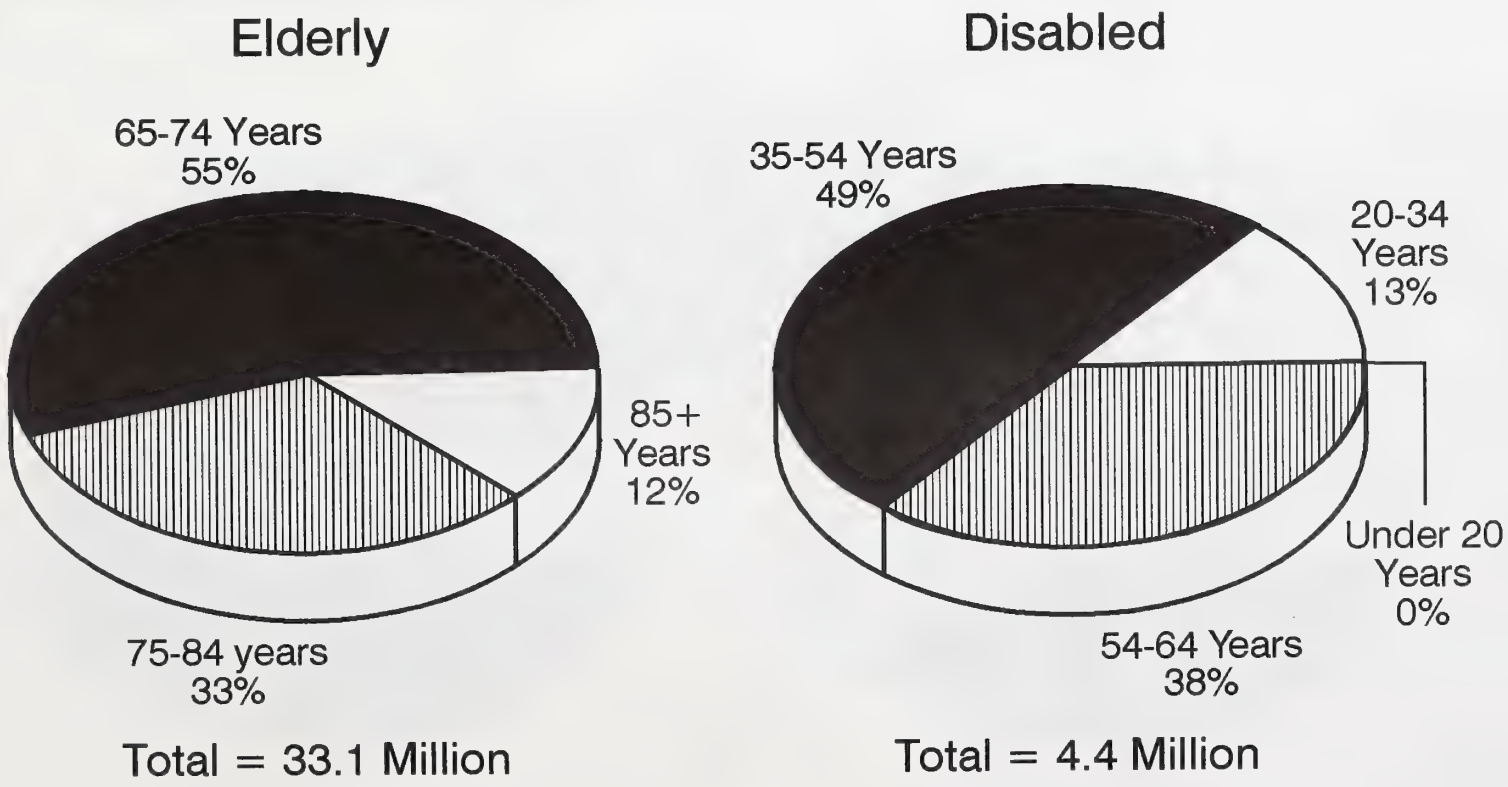
Total Beneficiaries = 37.5 Million

Source: HCFA/Office of the Actuary, 1996

Gender Distribution Of Medicare Beneficiaries, 1995

Source: HCFA/Office of the Actuary, 1996

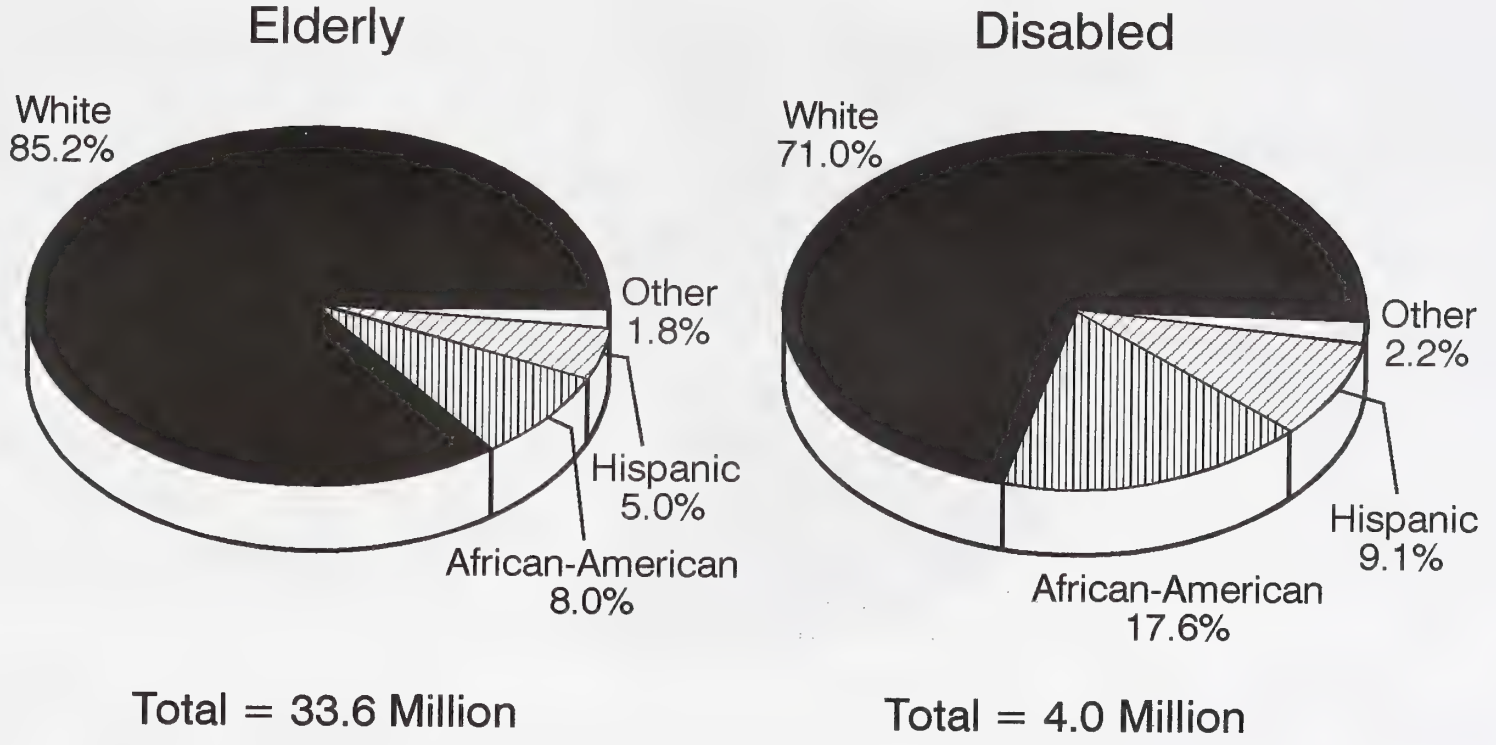
Age Distribution Of Medicare Beneficiaries, 1995



*Note: The percent of disabled Medicare beneficiaries under age 20 is 0.1%, or approximately 4,000 beneficiaries.
Source: HCFA/Office of the Actuary, 1996

Race/Ethnicity Distribution Of Medicare Beneficiaries, 1993

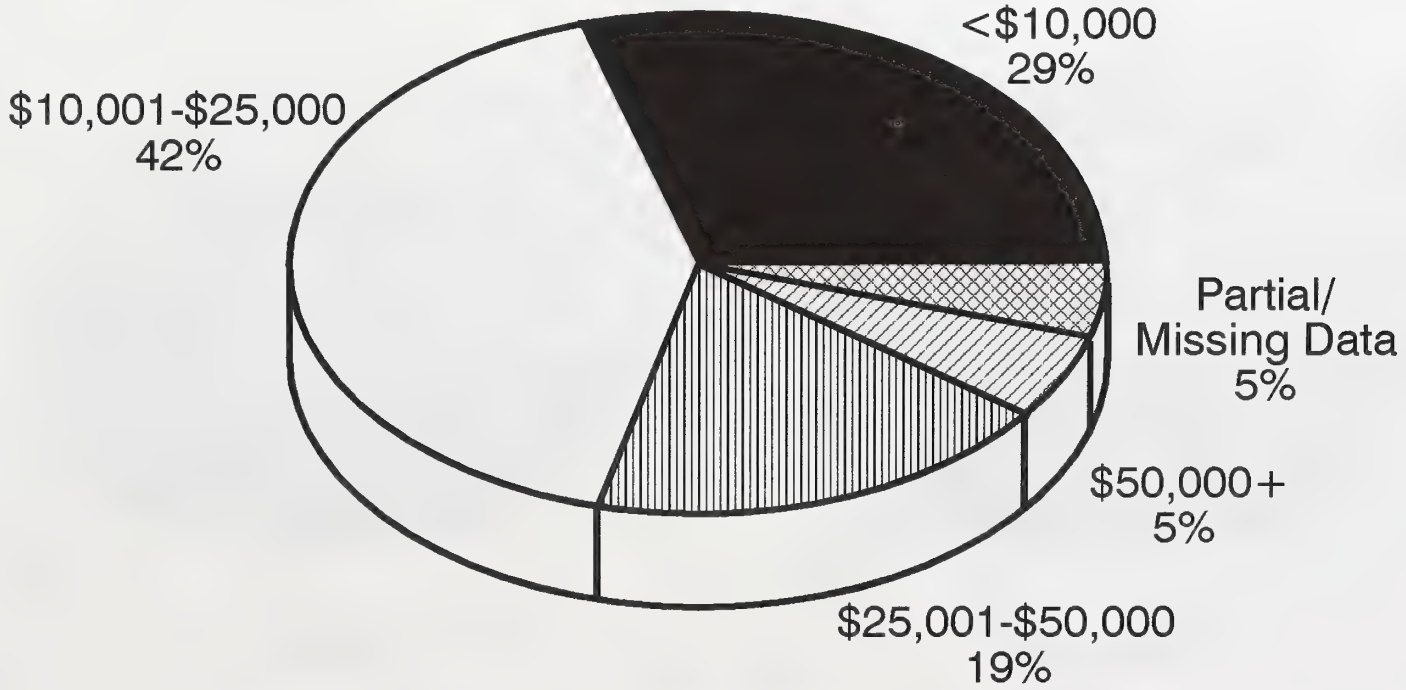
African-American And Hispanic Beneficiaries Are Disproportionately Represented Among The Disabled



Source: HCFA/Office of the Actuary; data from the Medicare Current Beneficiary Survey

Income Distribution Of Elderly Medicare Beneficiaries, 1993

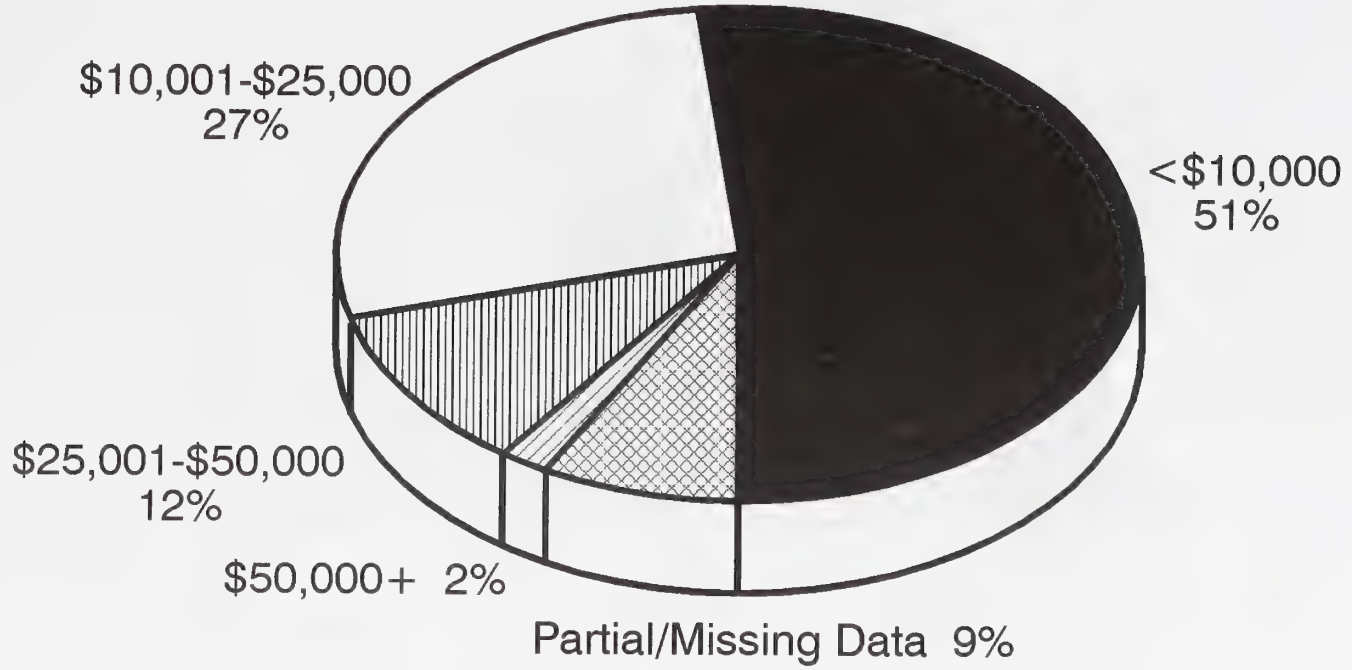
Nearly Three-Quarters Reported Incomes Of $25,000 Or Less



Note: Income represents total gross income, and includes pensions, Social Security Railroad Retirement and disability payments; the cash value of food stamps and public assistance payments; capital gains, annuities, VA and Workers' Compensation benefits; interest, dividends, and work-related income. The MCBS collects data on the income of the beneficiary, and spouse if applicable.
Source: HCFA/Office of the Actuary, data from the Medicare Current Beneficiary Survey

Income Distribution Of Disabled Medicare Beneficiaries, 1993

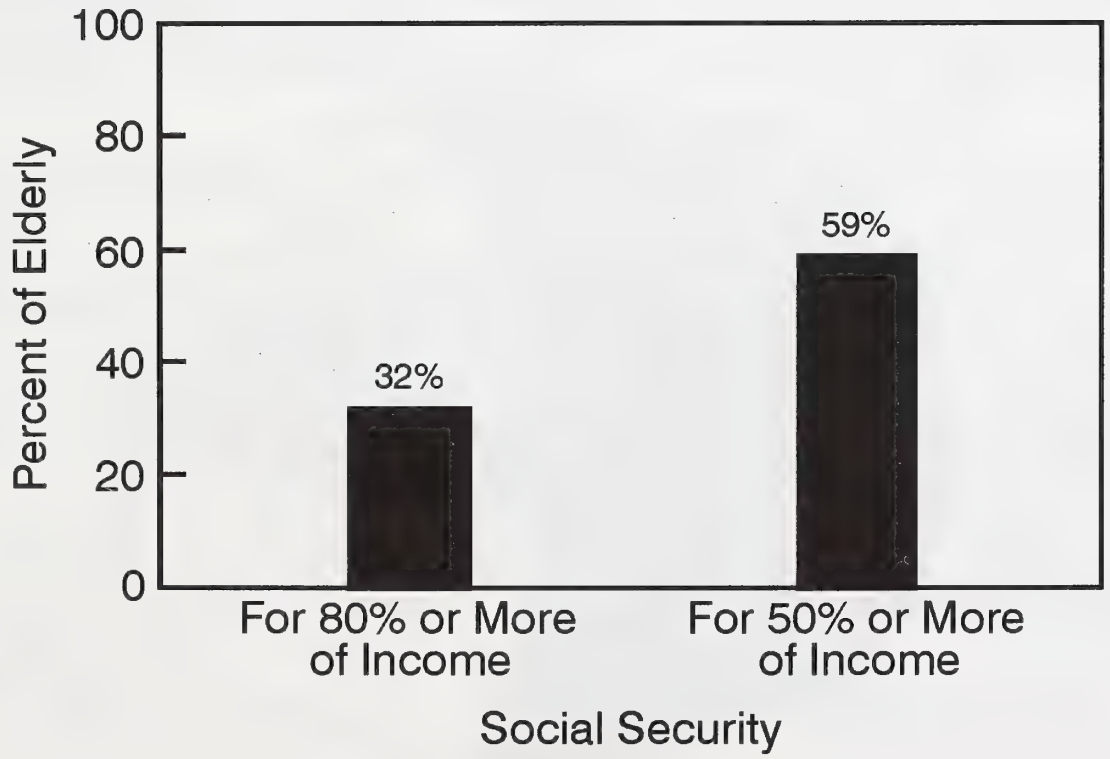
More Than Three-Quarters Reported Incomes Of $25,000 Or Less
Half Have Incomes Under $10,000



Note: Income represents total gross income, and includes pensions, Social Security Railroad Retirement and disability payments; the cash value of food stamps and public assistance payments; capital gains, annuities, VA and Workers' Compensation benefits; interest, dividends, and work-related income. The MCBS collects data on the income of the beneficiary, and spouse if applicable.
Source: HCFA/Office of the Actuary, data from the Medicare Current Beneficiary Survey

Percent Of Elderly Relying On Social Security, 1992

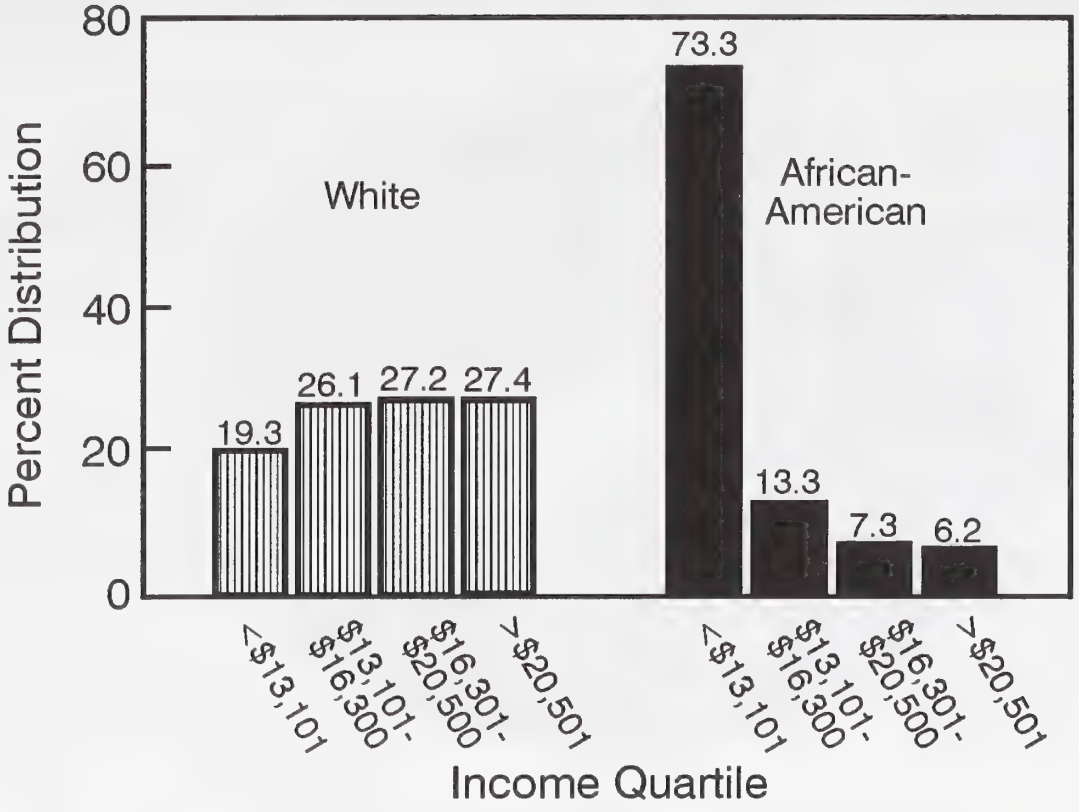
Many Medicare Beneficiaries Depend On Their Social Security For Much Of Their Income



Source: S. Grad, Income of the Population 55 or Older, 1992 (U.S. Government Printing Office, Washington, DC, 1994)

Medicare Aged Population By Race and Income, 1993

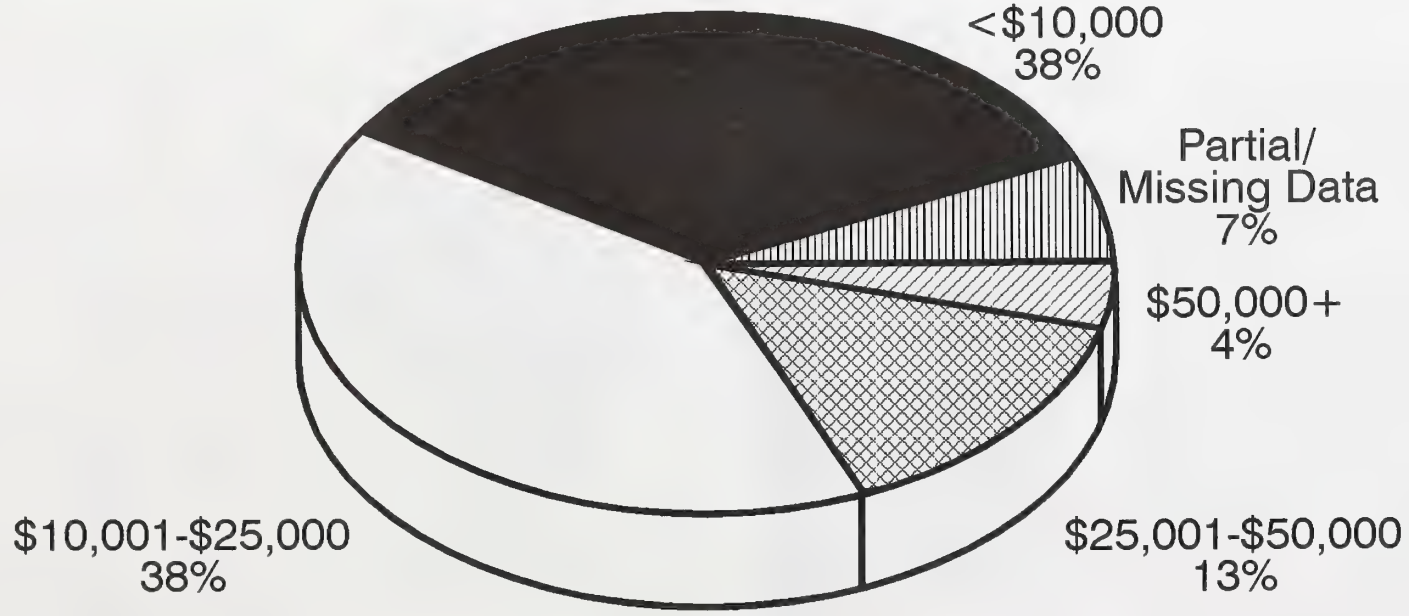
There Are Substantial Differences In The Income Distributions Of Medicare Beneficiaries Across Race



Source: Summary Report to Congress: Monitoring the Impact of Medicare Physician Payment Reform on Utilization and Access, 1995

Share Of Program Expenditures For FFS Beneficiaries, By Income, 1993

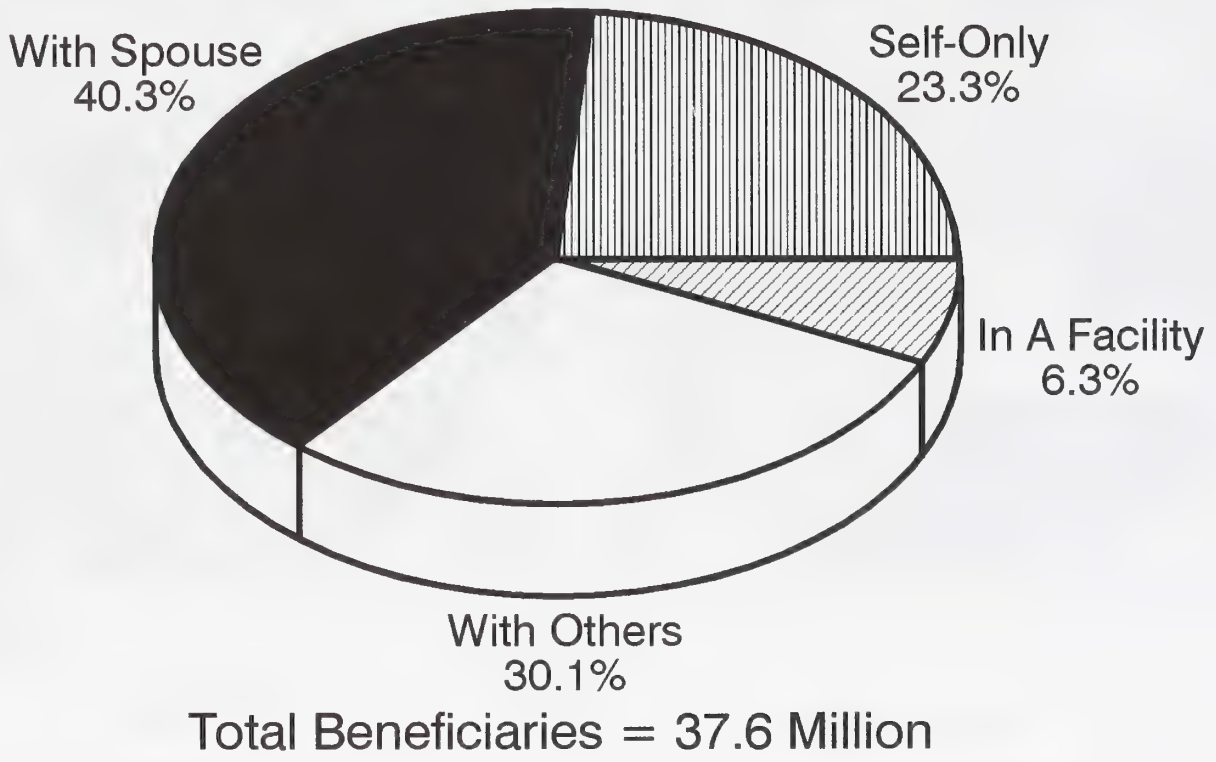
76% Of Program Expenditures Spent On Behalf Of Individuals With Annual Income Of $25,000 Or Less



Note: Excludes HMO enrollees.
Source: HCFA/Office of the Actuary, data from the Medicare Current Beneficiary Survey

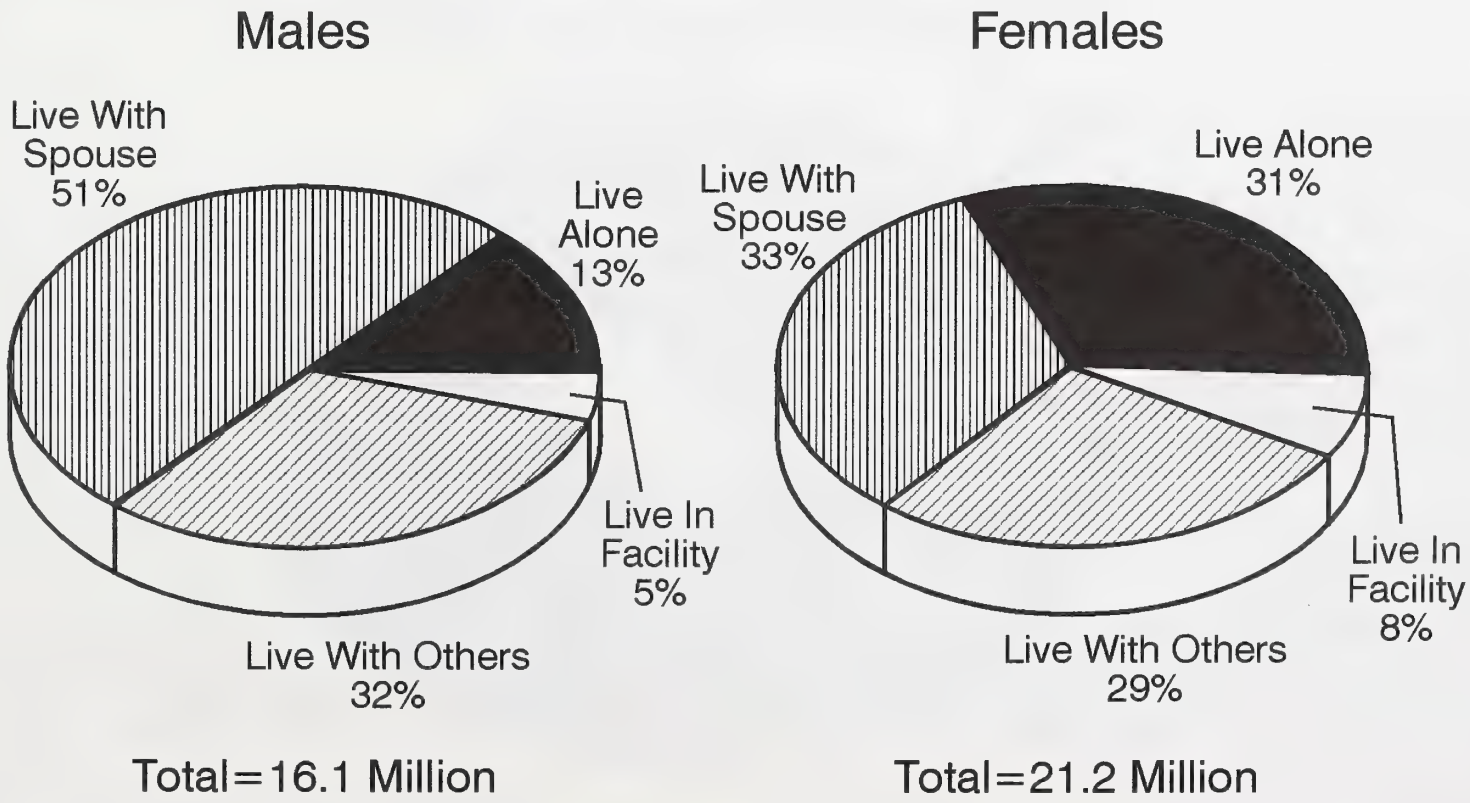
Living Arrangements Of Medicare Beneficiaries, 1993

Nearly One-Quarter Of Medicare Beneficiaries Live Alone



Source: HCFA/Office of the Actuary, data from the Medicare Current Beneficiary Survey

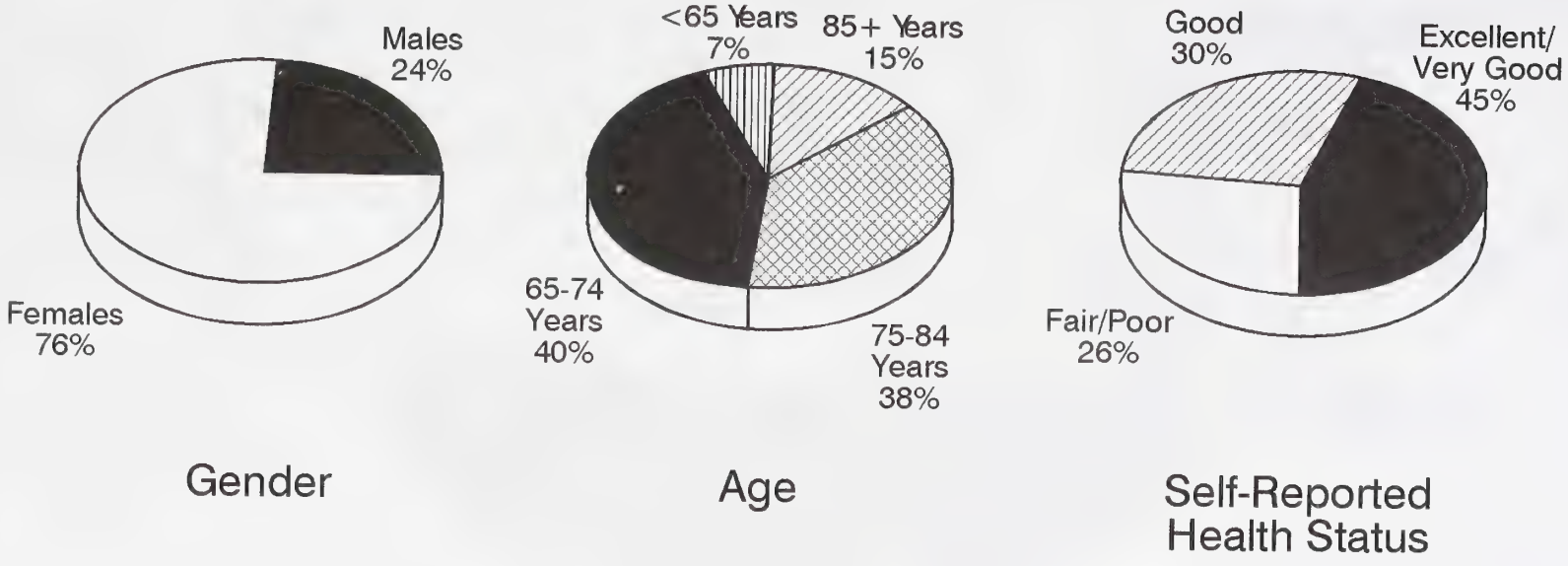
Living Arrangements Of Medicare Beneficiaries By Gender, 1993



Source: HCFA/Office of the Actuary; data from the Medicare Current Beneficiary Survey

Medicare Beneficiaries Who Live Alone, 1993

Three-Quarters Of This Population Are Women, 15% Are Very Elderly, And One-Quarter Rate Their Health As Fair Or Poor

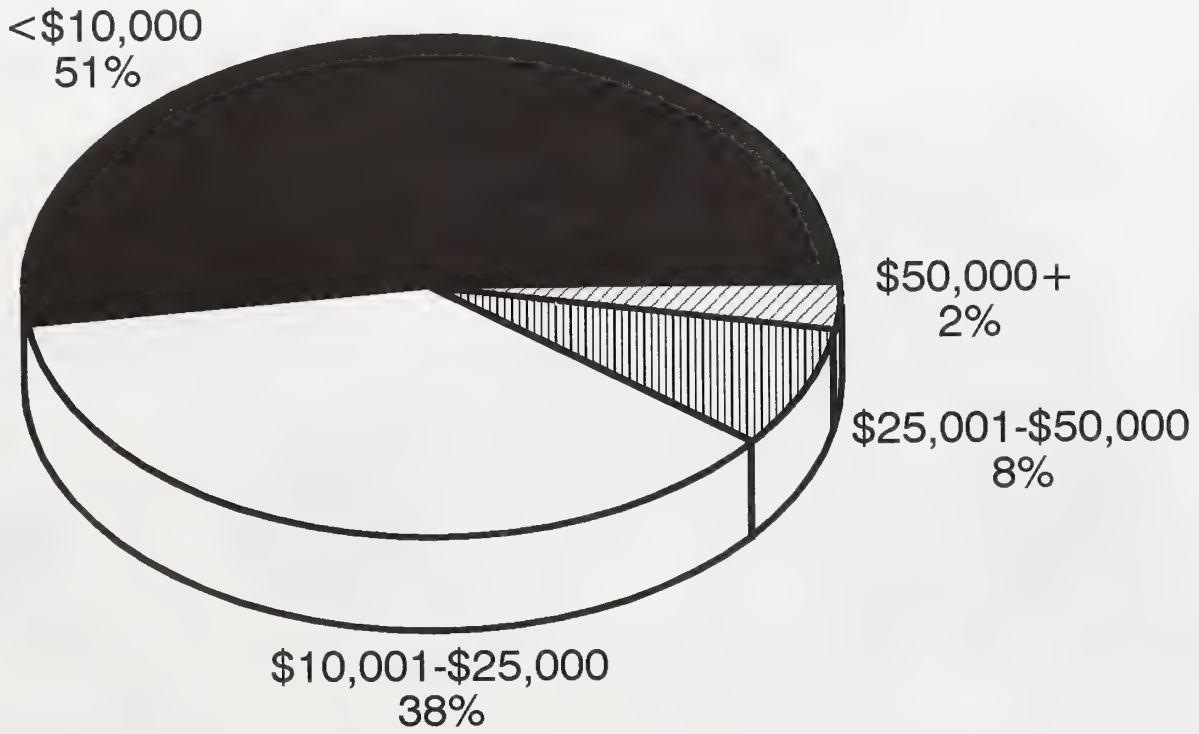


Total Beneficiaries Who Live Alone = 8.7 Million

Source: HCFA/Office of the Actuary; data from the Medicare Current Beneficiary Survey

Medicare Beneficiaries Who Live Alone, By Income, 1993

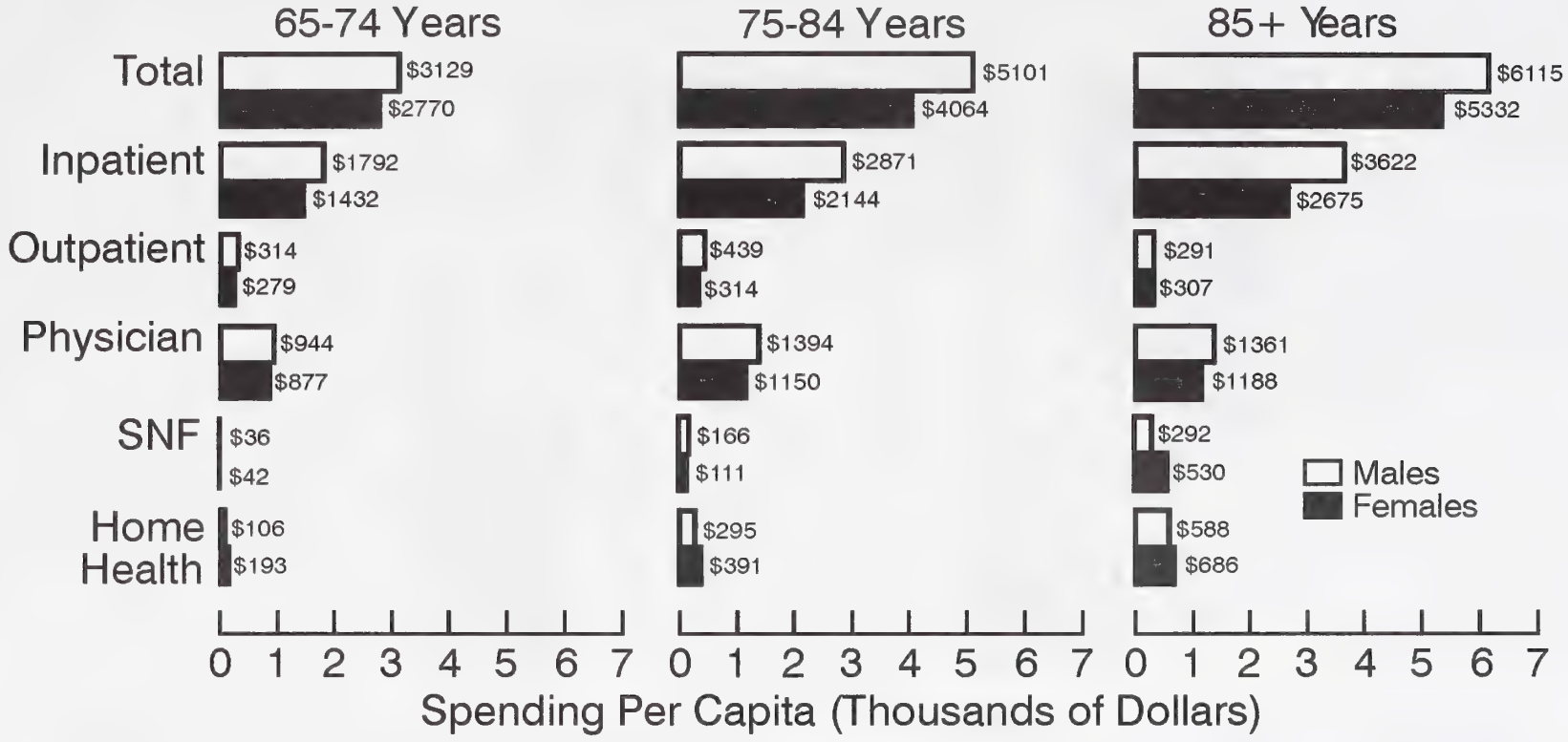
More Than Half Have Incomes Under $10,000



Source: HCFA/Office of the Actuary, data from the Medicare Current Beneficiary Survey

Medicare Spending Per Capita By Age And Gender, 1993

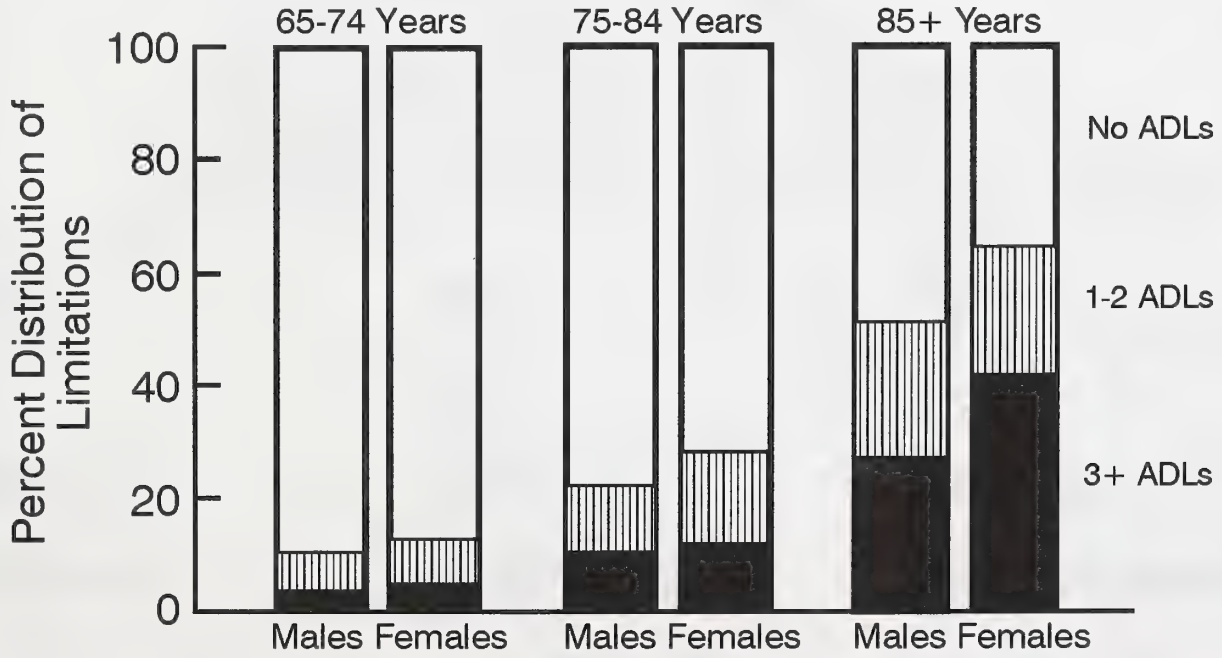
Spending Increases As Beneficiaries Age; Men Have Higher Per Capita Spending For Inpatient, Outpatient, And Physician Services, Women Have Higher Spending For SNF And Home Health Services



Source: HCFA/Office of the Actuary; data from the Medicare Current Beneficiary Survey

Functional Status Of Elderly Medicare Beneficiaries, By Gender And Age, 1993

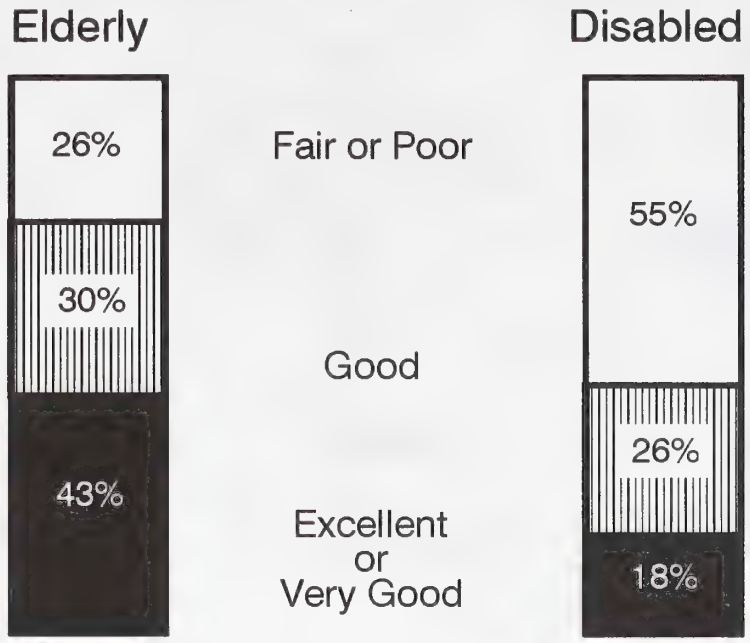
The Disparity In Functional Status Between Males And Females Becomes Larger As They Get Older: 42% Of Women Over The Age 85 Have Three Or More Limitations In Activities Of Daily Living, Compared To Only 27% Of Men Over Age 85



Note: ADL=Activity of Daily Living (e.g., eating, toileting, dressing)
Source: HCFA/Office of the Actuary; data from the Medicare Current Beneficiary Survey

Self-Reported Health Status Of Medicare Beneficiaries, 1993

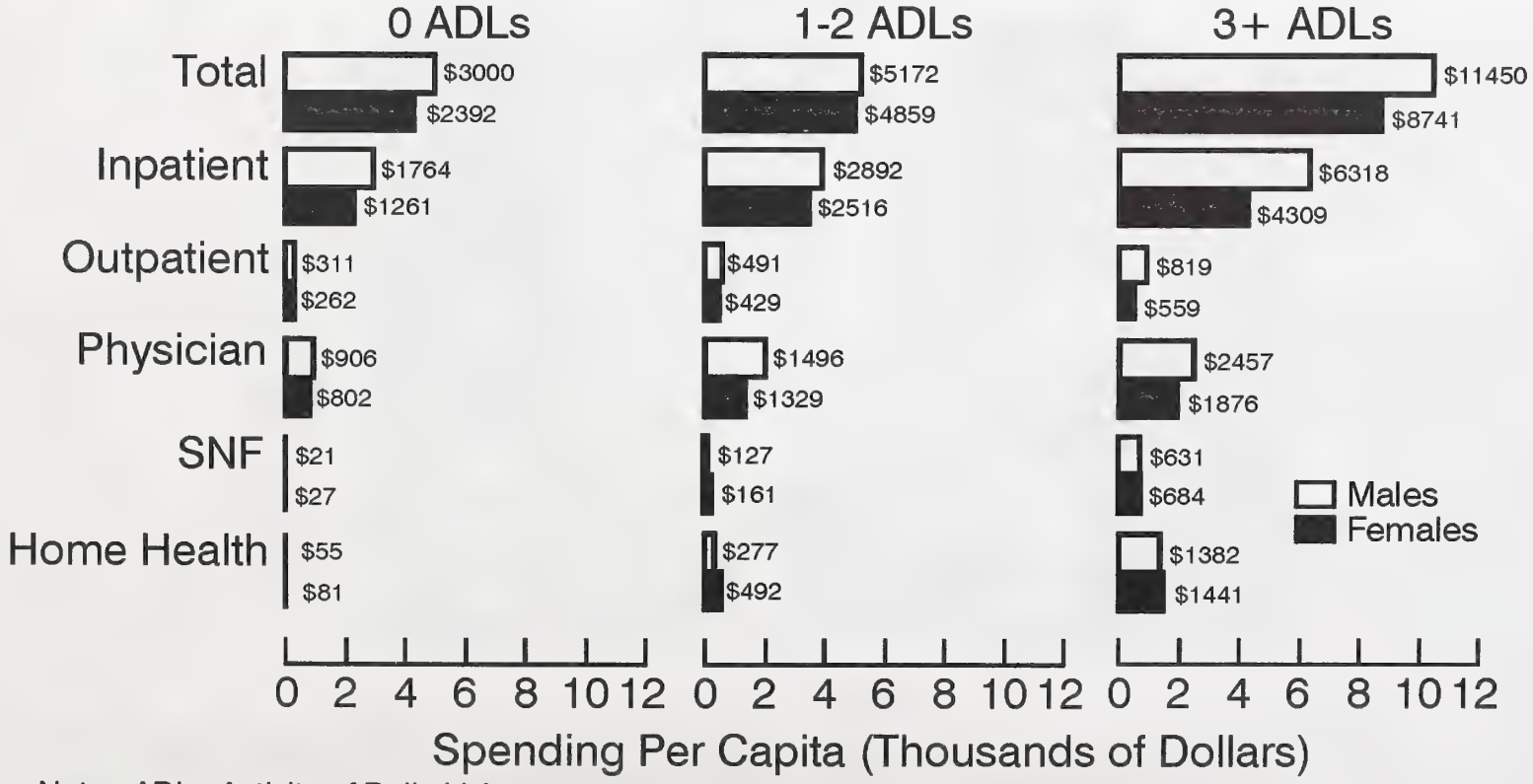
When Asked To Rate Their Own Health, More Than Half Of The Disabled And A Quarter Of The Elderly Feel They Are In Fair Or Poor Health



Source: HCFA/Office of the Actuary; data from the Medicare Current Beneficiary Survey

Medicare Spending Per Capita By Functional Status And Gender, 1993

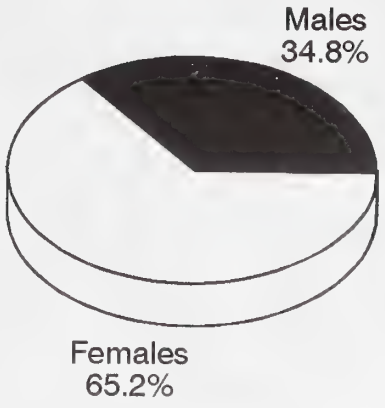
Spending Increases As Functional Status Deteriorates; Men Have Higher Per Capita Spending For Inpatient, Outpatient, And Physician Services, Women Have Higher Spending For SNF And Home Health Services



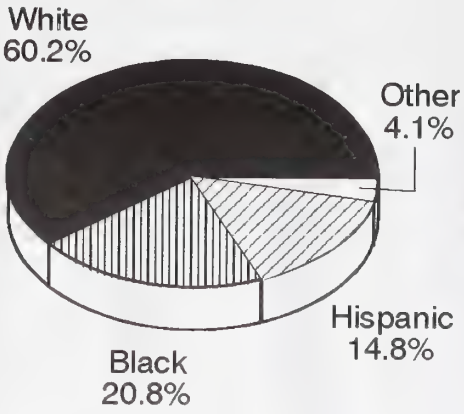
Note: ADL=Activity of Daily Living
Source: HCFA/Office of the Actuary; data from the Medicare Current Beneficiary Survey

Dual-Eligibles,* 1993

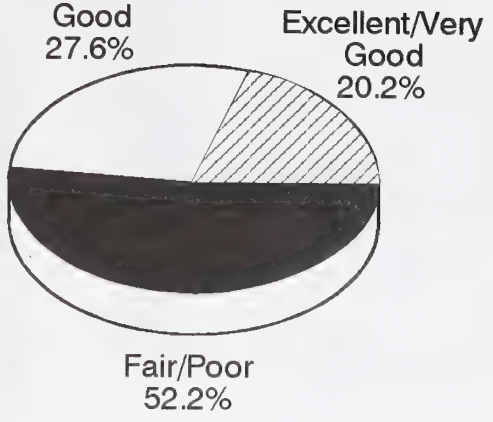
Nearly Two-Thirds Are Women And, Compared To The General Medicare Population, African-Americans And Hispanics Are Over-Represented And They Are More Likely To Rate Their Health As Fair Or Poor



Gender



Race/Ethnicity

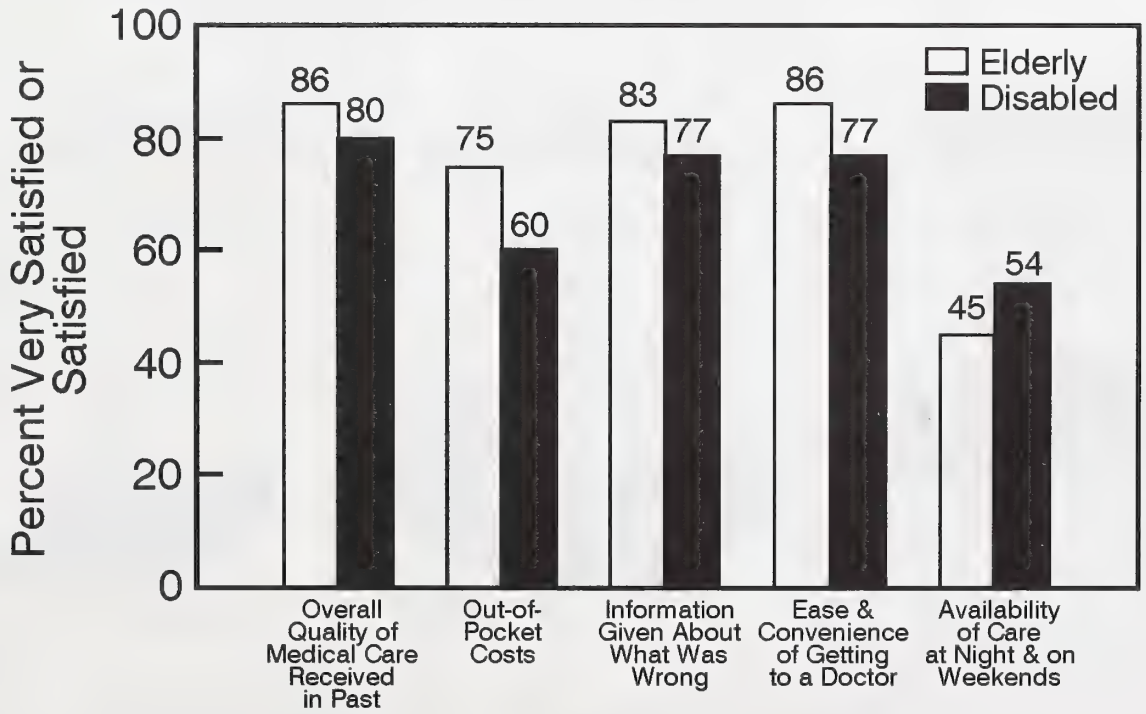


Self-Reported Health Status

*Note: Dual-elgibles are defined here as individuals who have been enrolled in both Medicare and Medicaid at some point in the year. The MCBS data cannot distinguish between QMBs, SLMBs and those entitled to full Medicaid benefits.
Source: HCFA/Office of the Actuary, 1996

Medicare Beneficiaries Rate Satisfaction With Medical Care,1993

Medicare Beneficiaries Are Generally Satisfied With The Overall Quality Of Medical Care They Receive



Source: HCFA/Office of the Actuary; data from the Medicare Current Beneficiary Survey

Access to Health Services in Medicare

The term access to care has been defined as the ability of individuals or population groups to obtain needed medical services. A number of financial and non-financial barriers may affect beneficiaries' access to needed health care services. Some barriers to access, such as education, language, location, health status and income, are not directly related to the health care system. Others involve primarily the financing and organization of the health care system, including the availability of insurance coverage and the number and distribution of providers, along with their willingness to treat certain populations.

Access and Medicare Physician Payment Reform

In establishing Medicare physician payment reform, the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) called for monitoring the effects of reform on Medicare beneficiaries' use of services, as well as changes in beneficiaries' financial liabilities.

The evidence indicates that the Medicare Fee Schedule, designed primarily as a tool to improve control of program expenditures, did not impair access to care for most beneficiaries. For services where payment levels were reduced, Medicare claims data show no systematic drop in utilization, and beneficiary surveys indicate that few have had trouble obtaining care and most are satisfied with the care they receive. In addition, physician participation in Medicare continues to grow.

- Overall use of physician services climbed from 1991 through 1994. Use of all services rose at an annual rate of 3.8%. Services with payment rate increases and those with decreases both were used more often (Chart A-1).

Medicare physician payment reform was intended to protect beneficiaries from large out-of-pocket expenses that could become a barrier to access to physicians' services. OBRA '89 specified a limit on the amount that physicians can charge beneficiaries above the Medicare payment rate. Complementing this charge limit, Congress provided incentives for physicians to become "participating providers". Participating physicians agree not to bill **any** Medicare beneficiary more than 20% of the charges allowed by the program, thus limiting the beneficiary's co-payment. These physicians are paid Medicare Fee Schedule payment rates whereas nonparticipating physicians are paid 95% of those rates. In addition, the names of participating physicians are listed in a published directory made available to beneficiaries.

- The proportion of physicians in the U.S. enrolled in the Participating Physician and Supplier (PAR) program has increased steadily to 72 % in 1995.

- The percent of Medicare expenditures for physician services paid to participating physicians grew from 67 % in 1990 to 89% in 1994 (Chart A-2).

Access for vulnerable populations

Although there is no evidence that Medicare physician payment reform created new barriers to care, there are particular vulnerable populations that historically have experienced problems with access to care. These overlapping groups include the disabled, the dually eligible, beneficiaries with low incomes, the very old (85 years and older), ethnic minorities, and persons living in rural areas, or in those designated as health professional shortage areas.

- Beneficiaries living in rural areas, poverty areas, or those designated as health professional shortage areas tend to have lower outpatient visit rates and higher emergency room visit rates (Charts A-3 and A-4).

- A variety of population groups have significantly higher rates of hospitalization for "ambulatory care sensitive conditions" (ACS). These are medical conditions that are responsive to good and continuous ambulatory care, for example, asthma or diabetes. In 1993, Medicaid-eligible beneficiaries, the very old and the non-elderly disabled had potentially avoidable hospitalization rates for these conditions that were approximately double that of the total population of Medicare beneficiaries (Chart A-5).

- Between 1991 and 1993, the disabled were two to three times more likely than the elderly to report having had a health problem the previous year but not receiving care (Chart A-6).

Many beneficiaries acquire private insurance ("Medigap") to supplement their Medicare benefits. Supplemental insurance reduces or eliminates out-of-pocket expenses, including Medicare cost-sharing and costs for services not covered by Medicare. Surveys show that many low-income elderly consider supplementary insurance more a necessity than an optional purchase.

- Elderly beneficiaries with neither private insurance policies nor additional public coverage have fewer physician visits than those in the dually insured categories (Chart A-7).

Given that low-income beneficiaries tend to have poorer health status than those in higher income groups, this variation suggests that higher out-of-pocket costs may limit service utilization for those without supplemental insurance coverage. This finding is consistent with recent research showing that supplemental insurance improves access to health care services[1].

- Disabled Medicare beneficiaries are less likely to have supplemental insurance coverage, indicating that this population with high levels of functional impairment and poor health status may face more serious financial barriers to needed services than the elderly. Only 34% of the non-elderly disabled living in the community have private supplementary insurance coverage. An additional 37% have Medicaid, and 25% have Medicare only. As noted in the Profile chapter, disabled beneficiaries tend to be poorer, and thus, less likely to have Medigap policies than their aged counterparts. In addition, law guarantees the availability of supplemental insurance policies to elderly beneficiaries (through a limited six month open enrollment period upon Medicare eligibility) but **not** to the Medicare disabled, except in a few States.

Access and income

The correlation between higher income and improved health status frequently described in the health literature applies to the elderly population of Medicare beneficiaries as well. Medicare out-of-pocket

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[1] Blustein, Jan: "Medicare Coverage, Supplemental Insurance, and the Use of Mammography by Older Women". *New England Journal of Medicine,* April 27, 1995.

This study concluded that use of mammography was substantially below recommended levels during the first two years of Medicare coverage for screening mammography. Women lacking supplemental insurance were at particularly high risk of failing to undergo mammography. Requiring co-payments for preventive services was identified as an obstacle to the effective mass screening of older women for breast cancer.

costs, however, affect access to primary care mostly for low-income beneficiaries.

- In 1993, the rate of hospitalization for elderly Medicare beneficiaries increased as income decreased[2] (Chart A-8). Since hospital admissions are based on need for care as clinically evaluated by a professional, the finding shows that beneficiaries with lower incomes are more likely to become seriously ill.

- In contrast, ambulatory physician visit rates for elderly beneficiaries tend to decline as income declines (Chart A-9).

The findings suggest that, although the health status of beneficiaries tends to decline as income declines, cost considerations (such as lack of supplemental insurance coverage and higher out-of-pocket expenses at the time of service) may inhibit self-initiated consultations with a physician. This postponement of primary ambulatory care, in turn, contributes to the higher rates of avoidable hospitalizations noted above.

Also shown is that the ambulatory physician visit rate for African American beneficiaries was generally lower than for white beneficiaries, while total hospitalization rates were higher than those of white beneficiaries. These utilization patterns suggest that African Americans may experience more barriers to comprehensive and continuous care than white beneficiaries. In addition, recent analyses show that African American beneficiaries are at risk of experiencing barriers to various common "referral sensitive" procedures, such as coronary artery bypass graft (CABG) and percutaneous transluminal coronary angioplasty (PTCA)[3].

Socioeconomic status (as measured by income) may account for part of the racial differences in access to services. Low income, in and of itself, is a risk factor for poorer health status and suboptimal utilization of services for both African American and white Medicare beneficiaries.

- White elderly beneficiaries in the lowest income group had ambulatory physician visit rates in 1993 that were 18% less than those in the highest income group. The corresponding differential for African-American beneficiaries was 12%

- Among African-American beneficiaries in the lowest income group, rates of referral-sensitive procedures such as percutaneous transluminal coronary angioplasty (PTCA) were 24% lower than the rates for African-American beneficiaries in the highest income group. The corresponding difference for coronary artery bypass graft (CABG) was 16%.

- Hypertension, when poorly controlled in an ambulatory setting, increases the risk of stroke and other conditions that require hospitalization. Among white beneficiaries in the lowest income group of the population, the rate of hospitalization for hypertension was more than twice the rate of white beneficiaries in the highest income group.

Higher income patients of all races are more likely to live in areas with greater access to health care resources; they may also be offered different treatment options than lower income patients, or they may

---

[2] HCFA, *Report to Congress: Monitoring the Impact of Medicare Physician Payment Reform on Utilization and Access*.1995. Establishing four equal groupings based on the entire Medicare elderly population's income resulted in markedly different distributions by race. White beneficiaries were more evenly distributed across the four income groups. In contrast, 73.3% of African-American beneficiaries fell into the lowest income group and only 6.2% fell into the highest income group of the population (also see Profile section).

[3] HCFA, Report to Congress.1995.

be more likely to know about newer treatment options due to their educational attainment.

Standardization of income across races showed that if the income distributions for African- American beneficiaries and white beneficiaries were equal, the racial differences in utilization rates for many services would decrease, although generally by only a modest amount. But, for some services, such as ambulatory physician visits and mammography, the standardization of income significantly diminished the racial disparities -- indicating that low income among African- American and white beneficiaries plays a substantial role with regard to access to care for certain services.

Access to preventive services

Medicare covers a limited number of preventive services such as PAP smears, screening mammography, and hepatitis B, pneumococcal pneumonia, and influenza vaccines. The pattern of lower utilization by vulnerable groups applies to these services as well.

- Medicaid-eligible female beneficiaries, the very elderly, those living in poverty areas, and African-Americans displayed lower rates of use of screening mammography and PAP tests than female Medicare beneficiaries overall (Chart A-10).

The fact that Medicare pays the full approved charges for influenza and pneumonia vaccines and their administration, and that neither the annual deductible nor the 20% coinsurance applies to these services, suggests that factors other than cost of care per se are at work in creating wide variation of immunization rates among groups of beneficiaries (Chart A-11).

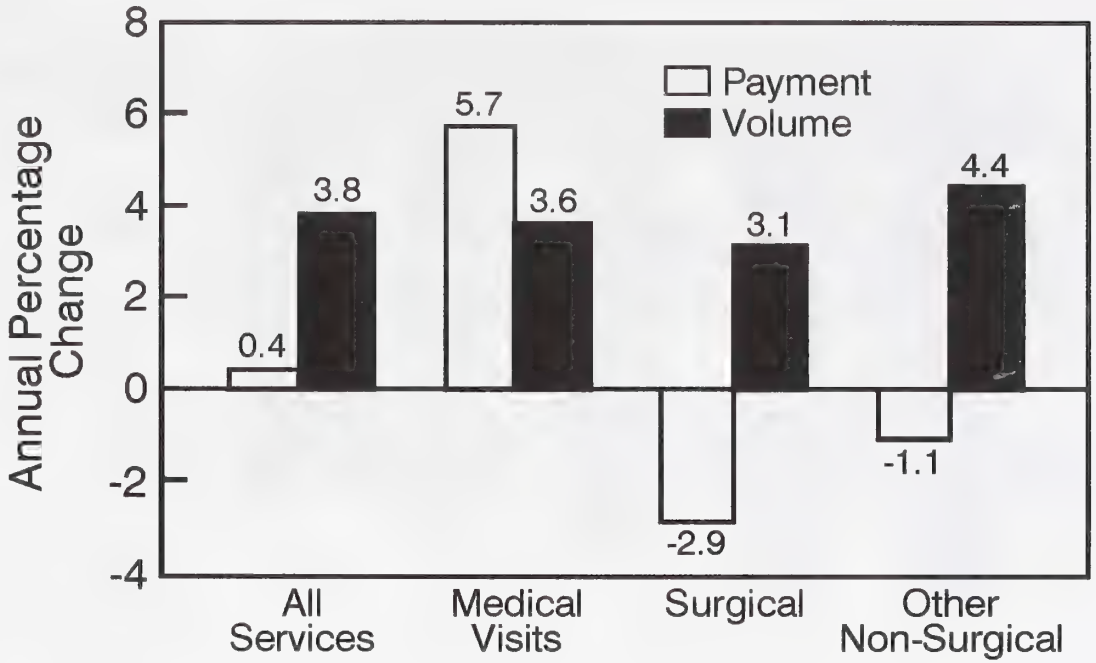
Conclusion

While we do not know the "right" level of health care utilization, clearly some Medicare beneficiary groups would benefit from increased access to primary care, preventive and other services.

Multiple approaches, from selectively reducing financial barriers for some health care services, to outreach efforts (like HCFA's consumer information campaigns regarding mammograms and the influenza vaccine) should be considered in order to maintain and expand access for vulnerable groups of Medicare beneficiaries.

Payment And Use Per Beneficiary , 1991-1994

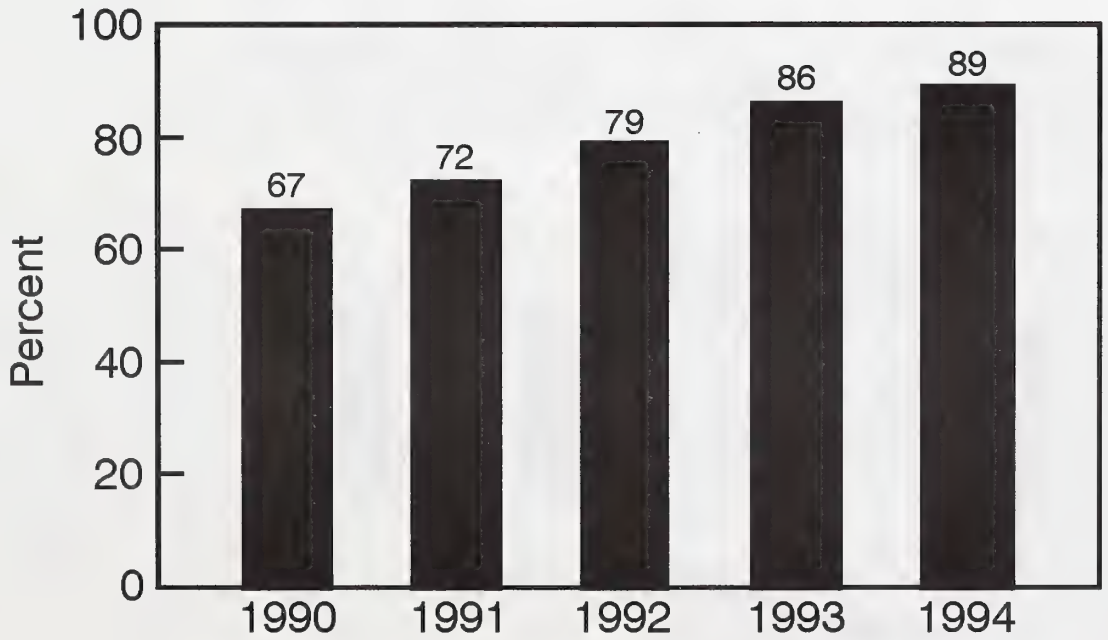
The volume of services to beneficiaries increased whether payment increased or decreased



Source: Physician Payment Review Commission; Annual Report to Congress, 1995.

Medicare Physician Expenditures Paid To Participating Physicians, 1990-1994

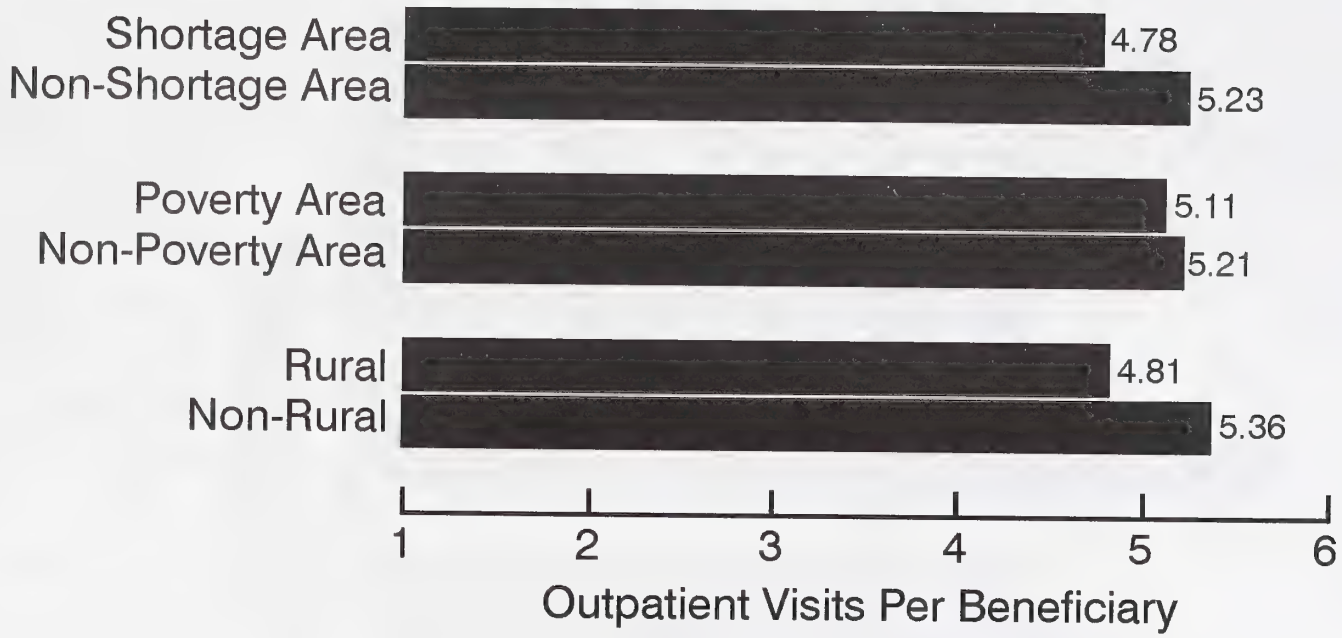
Medicare Participating Physician Spending Grew As A Share Of Overall Physician Spending



Source: HCFA, Bureau of Program Operations.

Outpatient Visit Rates In Selected Areas, 1992

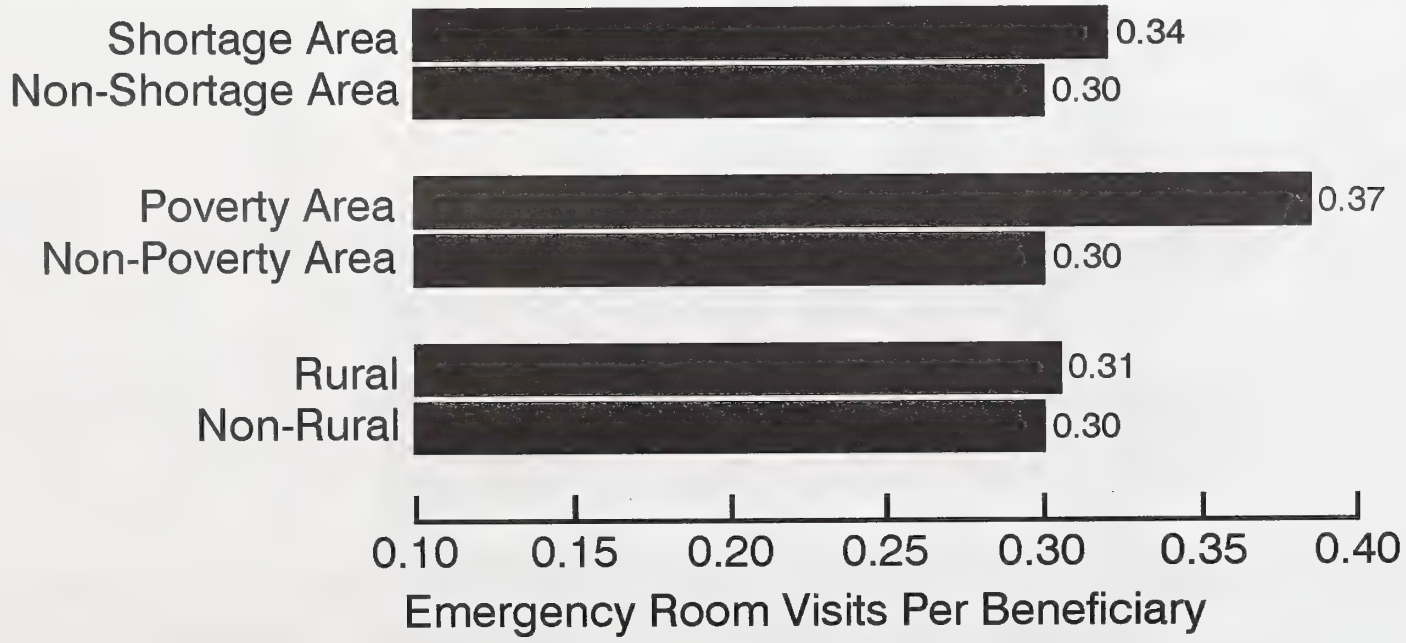
Beneficiaries Living In Rural, Poverty Or Health Professional Shortage Areas Had Lower Rates Of Outpatient Visits



Source: HCFA Report to Congress: Monitoring the Impact of Physician Payment Reform on Utilization and Access, 1995 (Data derived from Medicare Part B claims for a sample of beneficiaries.)

Emergency Room Visit Rates In Selected Areas, 1992

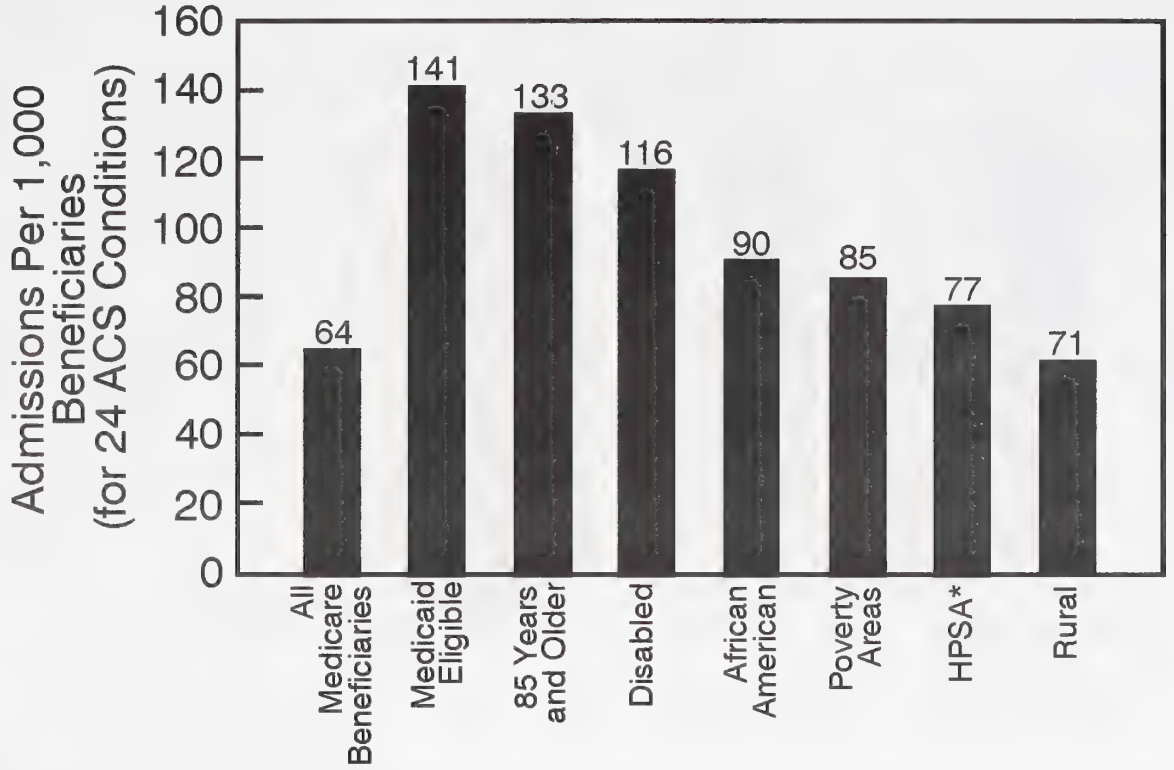
Beneficiaries Living In Rural, Poverty Or Health Professional Shortage Areas Had Higher Rates Of Visits To The Emergency Room



Source: HCFA Report to Congress: Monitoring the Impact of Physician Payment Reform on Utilization and Access, 1995 (Data derived from Medicare Part B claims for a sample of beneficiaries.)

Hospitalization Rates For Beneficiaries With "Ambulatory Care Sensitive Conditions", 1993

Vulnerable Groups Of Medicare Beneficiaries Had High Rates Of Avoidable Hospitalizations

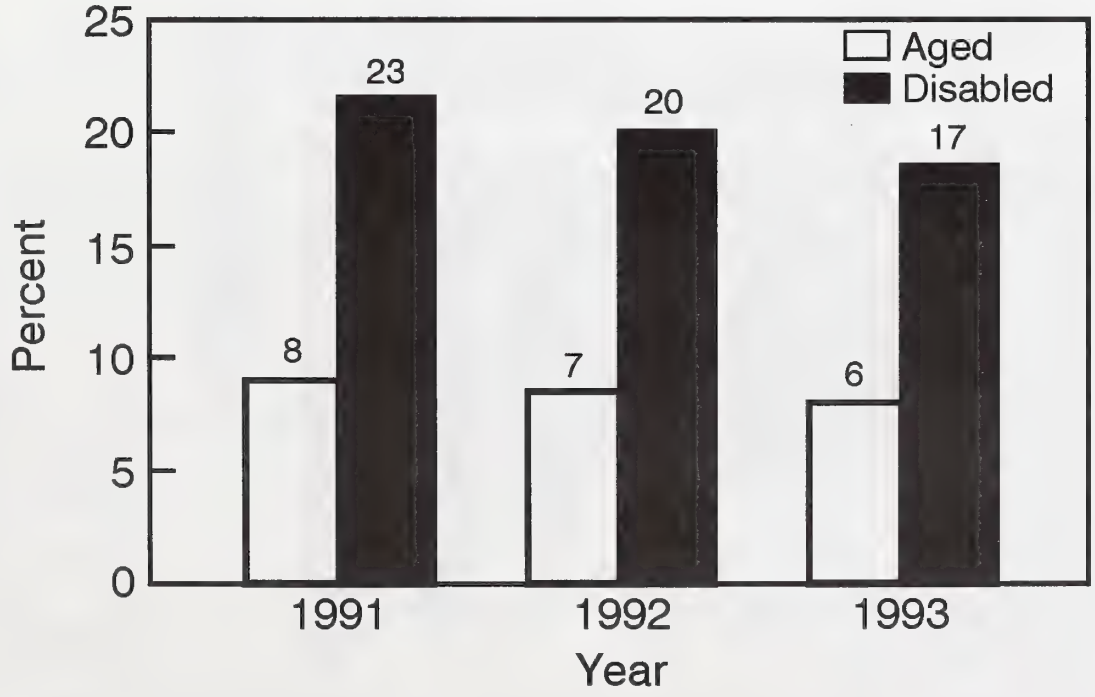


*Health Professional Shortage Area

Source: HCFA Report to Congress: Monitoring the Impact of Physician Payment Reform on Utilization and Assess, 1995 (Data from part A Claims for a sample of Medicare beneficiaries.)

Percent Of Beneficiaries Reporting A Health Problem And Not Receiving Care In Previous Year, 1991-1993

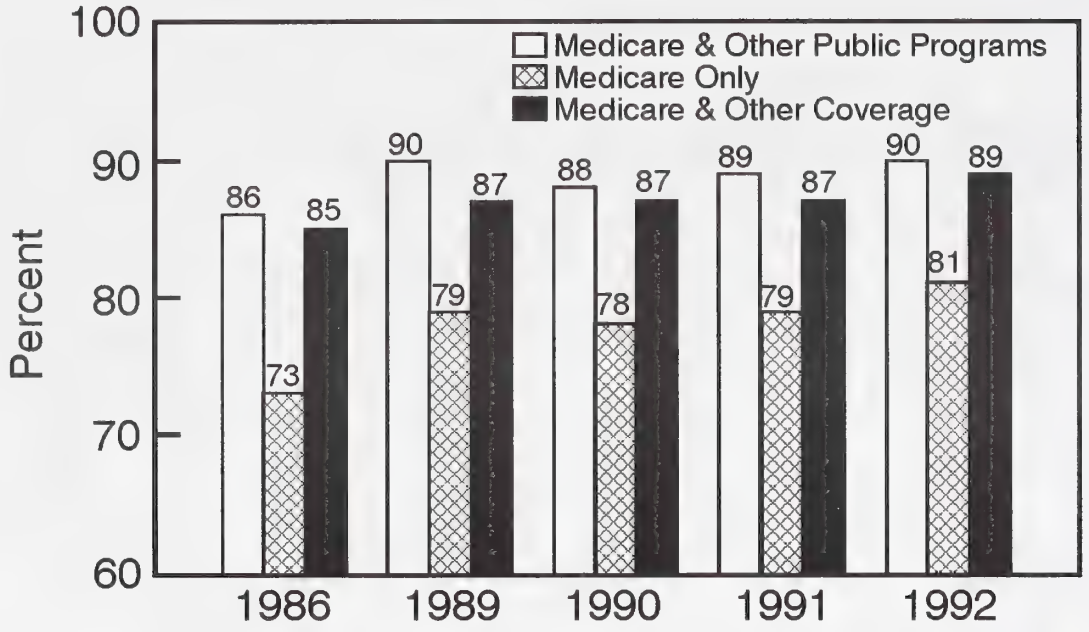
Disabled Beneficiaries Experienced Significantly Higher Barriers To Medical Services Than Elderly Beneficiaries



Source: HCFA, Medicare Current Beneficiary Survey (non-institutionalized beneficiaries). Rounds 1, 4 and 7 Data.

Percent Of Elderly Persons With A Physician Visit By Insurance Coverage, 1986, 1989-1992

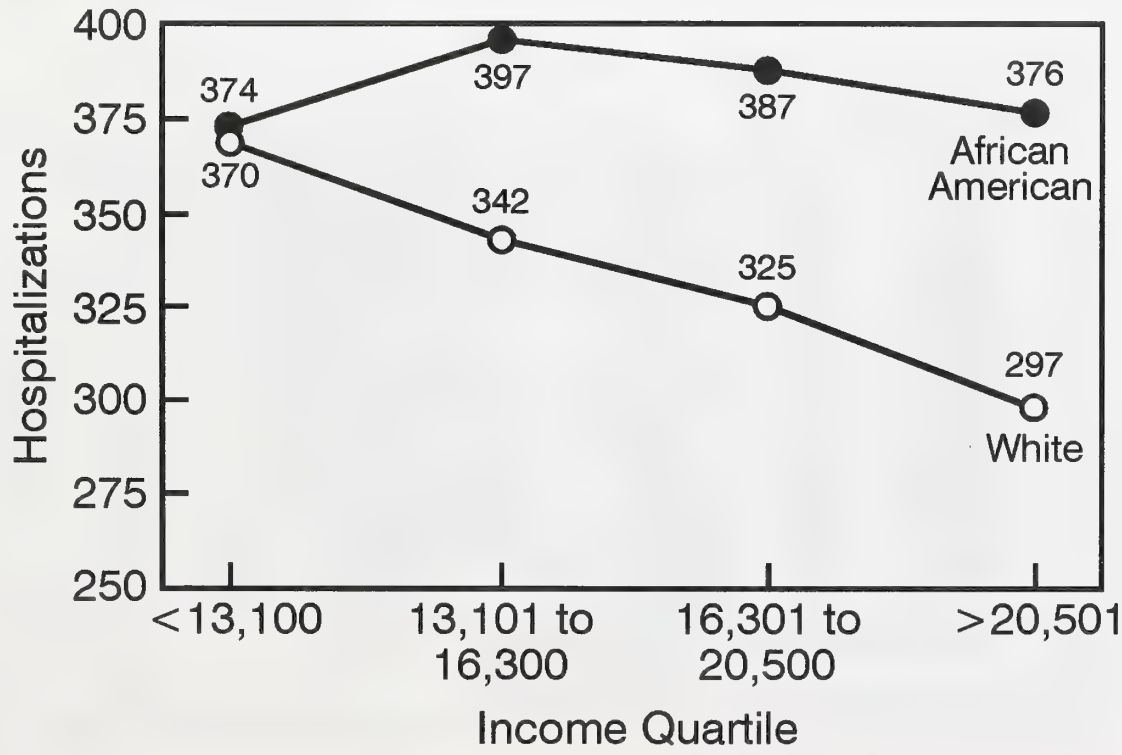
Of All Elderly Persons, Those Lacking Supplemental Insurance Were More Likely To Go Without Medical Visits.



Source: HCFA Report to Congress: Monitoring the Impact of Physician Payment Reform on Utilization and Access, 1995 (Data Derived from the National Health Interview Survey, National Center Health Statistics, 1984-1992.

Elderly Beneficiary Hospitalization Rate by Income, 1993

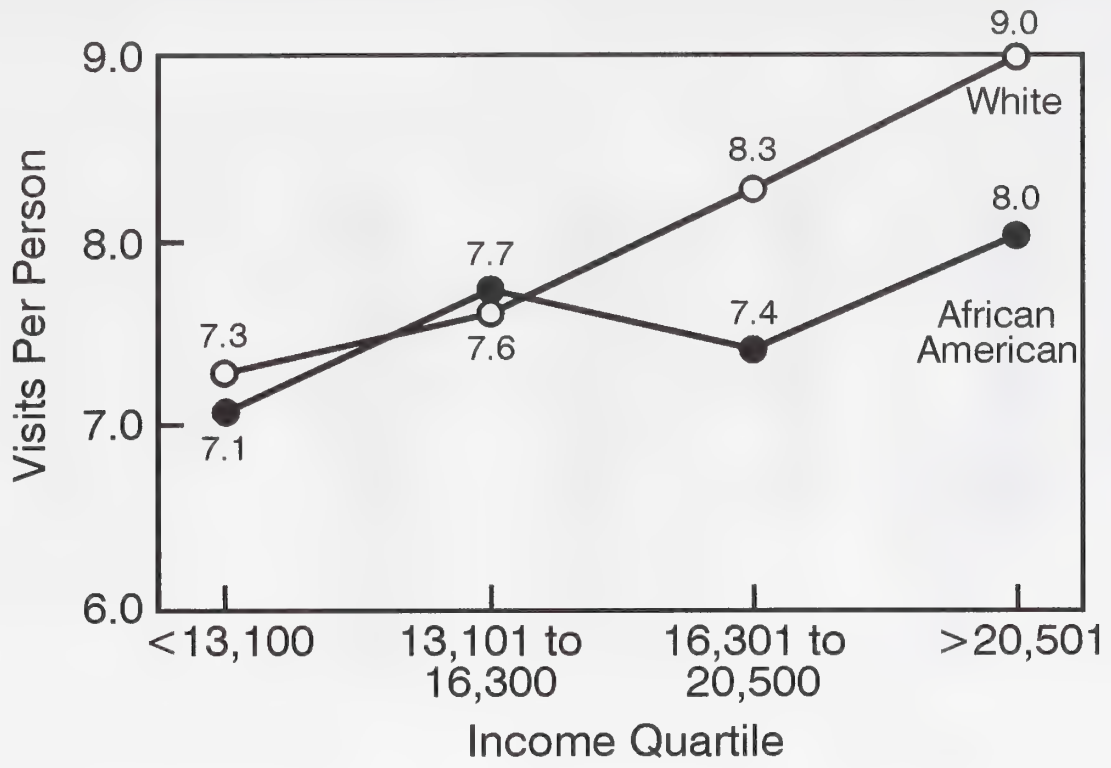
For All Diagnoses, Elderly Beneficiaries With Lower Income Tended To Have More Hospitalizations



Source: HCFA Report to Congress: Monitoring the Impact of Physician Payment Reform on Utilization and Access, 1995 (Data derived from Medicare Part B claims for a sample of beneficiaries.)

Ambulatory Visits Per Beneficiary By Income, 1993

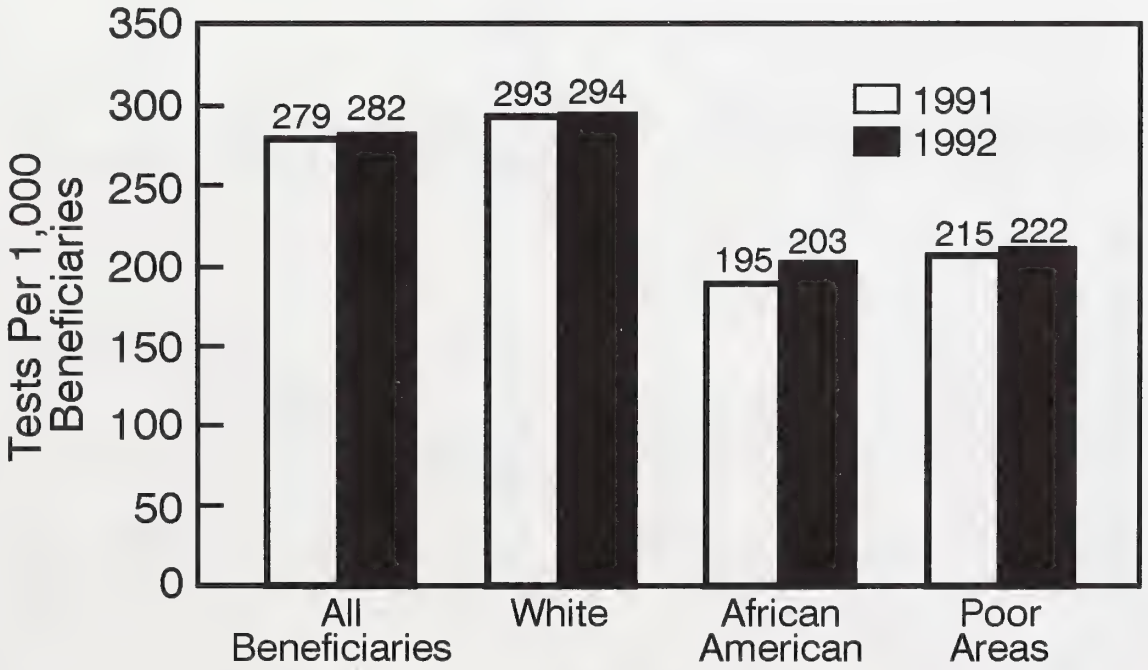
Elderly Beneficiaries With Lower Income Tended To Have Lower Rates Of Medical Visits



Source: HCFA Report to Congress; Monitoring the Impact of Physician Payment Reform on Utilization and Access, 1995 (Data derived from Medicare Part B claims for a sample of beneficiaries.)

Mammography Use By Medicare Beneficiaries, 1991-1992

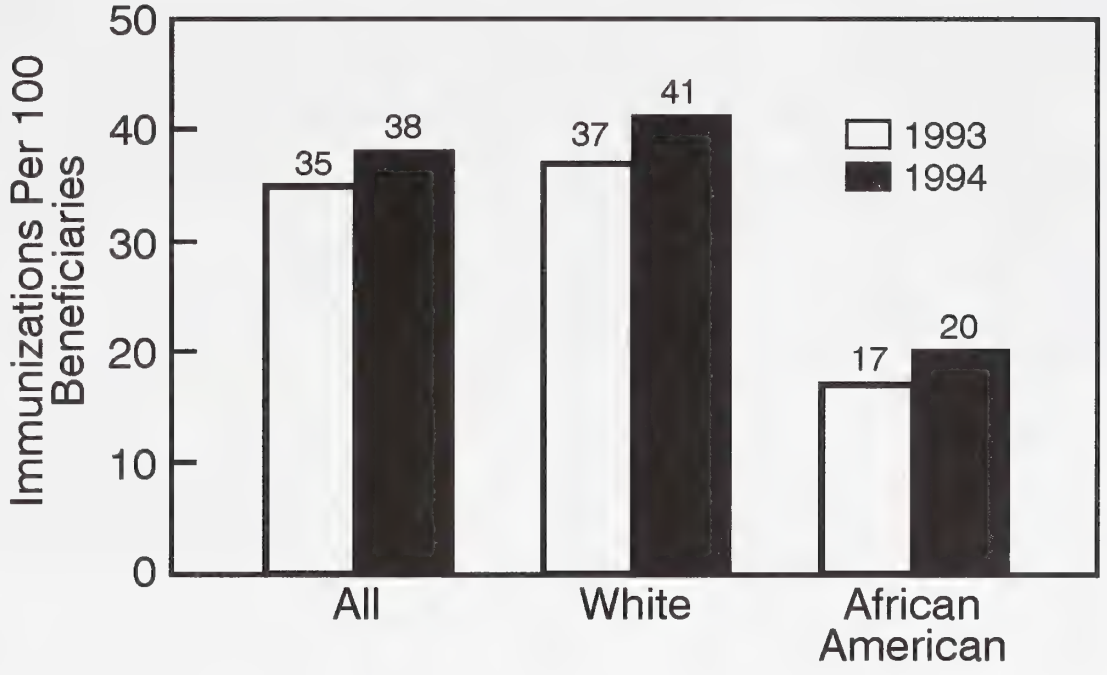
African American Female Utilization Rates Were Significantly Lower Than For White Beneficiaries



Source: HCFA Report to Congress: Monitoring the Impact of Physician Payment Reform on Utilization and Access, 1995 (Data derived from Medicare Part B claims for a sample of beneficiaries.)

Flu Immunization Rates For Elderly Beneficiaries By Race, 1993-1994

African-Americans Had Rates Of Flu Immunizations, A Service Offered By Medicare At No Cost, That Were Less Than Half Those Of White Beneficiaries



Source: U.S. Department of Health and Human Services/HCFA, Influenza Immunizations Paid for by Medicare, 1994.

HEALTH CARE SPENDING

Medicare and National Health Spending

In 1994, American's personal health care expenditures--spending for the direct consumption of health care goods and services--amounted to $832 billion. Although Medicare beneficiaries make up about 14% of Americans, Medicare's spending accounted for 20% of these personal health expenditures. This represents considerable growth since 1967 when Medicare (whose beneficiaries then made up 9.6% of the population) funded 10.8% of personal health care expenditures. However, Medicare's prominence varies widely across different types of personal health care spending (Chart H-1).

- Medicare paid for about one-third of personal health care spending on hospital care, home health care, and medical durables (e.g., wheelchairs, oxygen, vision products). Medicare also accounted for one-fifth of personal health spending on physicians' services.

- Medicare paid for 7.5% of the $72 billion Americans spent on nursing home care. Although relatively low, this proportion has increased substantially over the last three decades; before 1980, for example, Medicare covered less than 2% of nursing home expenditures.

- Medicare accounts for none of the nation's $121 billion in spending (15% of total spending) on medical nondurables--primarily outpatient prescription drugs--and dental services.

The Distribution of Medicare Spending Across Individuals

In 1993, Medicare spent an average of $3,385 a year on beneficiaries age 65 and older, $3,174 a year on beneficiaries under age 65 with disabilities, and $30,296 on non-elderly enrollees in the End-Stage Renal Disease (ESRD) Program. Yet in each case, only a small percentage of beneficiaries accounted for a disproportionate share of that group's total Medicare spending.

- More than one-half of Medicare's payments for elderly beneficiaries in 1993 were spent on the 5% of enrollees who incurred Medicare payments of $18,000 or more. This distribution of payments has remained stable during the past 20 years (Chart H-3).

- Compared with elderly beneficiaries, Medicare spending for beneficiaries with disabilities was only slightly more concentrated (Chart H-4).

- Even in the high-cost ESRD program, Medicare spending was concentrated on a disproportionately small number of people; more than one-half of Medicare's ESRD payments were spent on the 18% of ESRD enrollees who incurred $43,000 or more in payments (Chart H-5).

Beneficiaries Who Incur Relatively High or No Medicare Spending

Medicare beneficiaries age 65 and older who had no Medicare spending in 1993 had a persistent history of no or relatively low spending in the previous five years. In contrast, beneficiaries who were in the top 10% of spending in 1993 were increasingly unlikely in previous years to have generated high Medicare spending.

- Elderly beneficiaries who incurred no Medicare payments in 1993--and who were enrolled in Medicare during the previous five years--were overwhelmingly likely to have incurred no or very low Medicare payments over the past five years (Chart H-6). For example, 69% of the people in

this 1993 cohort (i.e., no Medicare spending) had no spending in 1992; 66% had no spending in 1991; and 68% had no spending in 1988.

- Relatively high Medicare spending is not as persistent as no Medicare spending. As a group, elderly beneficiaries who were in the top 10% of spenders move increasingly closer to lower spending categories through the five preceding years (Chart H-7). Only 26% of the people in this 1993 cohort (i.e., top 10%) were in the top 10% of spenders in 1992; 17%, in 1991; and only 8% were in the top 10% in 1988. At the other end, 17% of this cohort had no or relatively low spending (i.e., bottom 30%) in 1992; and 36% had no or low spending in 1988.

Health Spending as a Percentage of After-tax Income

Because total health care costs have grown rapidly, especially for those services not well covered by Medicare, health spending has been a rising burden on elderly households. Whereas the percentage of after-tax income spending over the last 20 years on health insurance, medical services, prescription drugs and medical supplies has been fairly steady for households headed by people younger than 65 (averaging 5.0% in 1994), the percentage for households headed by people age 65 and older has increased steadily (averaging 17.7% in 1994, Chart H-8). Moreover, the rate of increase in elderly households' spending is directly related to income (Chart H-10).

- Whether elderly or non-elderly, lower income households spend a higher percentage of after-tax income on health care than higher income households. However, income differences are starkest among the elderly. Among elderly households, those in the bottom income quintile spend about seven times more on health (as a percentage of their after-tax income) than those in the top income quintile. Among non-elderly households, those in the bottom income quintile spend roughly three times more than non-elderly households in the top income quintile.

- Among non-elderly households, health spending declined by 19% to 39% as a percentage of after-tax income between 1960-1961 and 1972-1973--generally, the higher the income quintile the steeper the decline (Chart H-9). Among elderly households, health spending as a percentage of after-tax income declined by a similar magnitude in the top two income quintiles (33% to 46%). But the decline was modest in the lower income quintiles--roughly 12% in the second and third income quintile, only 2% in the bottom quintile (Chart H-10).

- Since 1972-1973, health spending by non-elderly households above the bottom income quintile has been basically constant as a percentage of after-tax income. For households in the bottom quintile, health spending as a percentage of after-tax income climbed sharply from the early 1970s to about 1987, but has since drifted down to just below the percentage spent in 1960-61. Thus, spending for health care absorbed a smaller portion of non-elderly households' income in 1994 than in 1960-1961 (Chart H-9).

- In contrast, except for the top income quintile, health spending since 1972-1973 has been absorbing an increasingly large proportion of elderly households' disposable income (Chart H-10). Indeed, this increase has more than offset the decline that took place between 1960-61 and 1972-1973: Medicare beneficiaries in the first four income quintiles spent 4% to 106% more on health as a percentage of after-tax income in 1994 than in 1960-61 (the lower the income quintile, the greater the difference). Only in the top income quintile did health spending absorb a smaller portion of Medicare

beneficiaries' income in 1994 than in 1960-1961, as was the case for non-elderly households.

Health Care Coverage to Supplement Medicare

The overwhelming majority of Medicare beneficiaries have other health care coverage that supplements Medicare. Supplemental insurance is an important economic resource because Medicare covers less than one-half of beneficiaries' total health expenses--many beneficiaries depend on supplemental policies to help pay Medicare's significant cost-sharing requirements or for services that Medicare does not cover, such as outpatient prescription drugs.

- Among beneficiaries age 65 and over, about 70.5% had private health insurance, either provided by an employer or purchased individually and 12.8% receive full or partial help from Medicaid (Chart H-11). Disabled beneficiaries are less likely to have private health insurance (29.6%) and more likely to receive help from Medicaid (40.9%) (Chart H-12).

- Many beneficiaries with employer-provided insurance also purchase individual policies: about 7.7% of the elderly and 2.1% of the disabled have both employer-provided and individually purchased insurance.

- About 72% of people with employer-sponsored supplemental insurance policies have prescription drug coverage. Among people with Medigap insurance (individually purchased policies), the proportion with drug coverage is less than 25%.

Spending on Supplemental Health Insurance

When Medicare beneficiaries received supplemental health insurance through an employer in 1992, their out-of-pocket premiums averelderly $728. In contrast, beneficiaries who individually purchased Medigap policies paid an average of $1,014 a year in out-of-pocket premiums, an increase of almost 40% (Chart H-13).

- Average premiums paid by policyholders do not vary strongly with income. For example, people with incomes between $5,000 and $10,000 pay only $90 a year less for their Medigap policies ($955) than people with incomes between $35,000 and $50,000 ($972), and $136 a year more for their employer-sponsored coverage ($774 versus $638).

Outpatient Prescription Drug Coverage and Spending

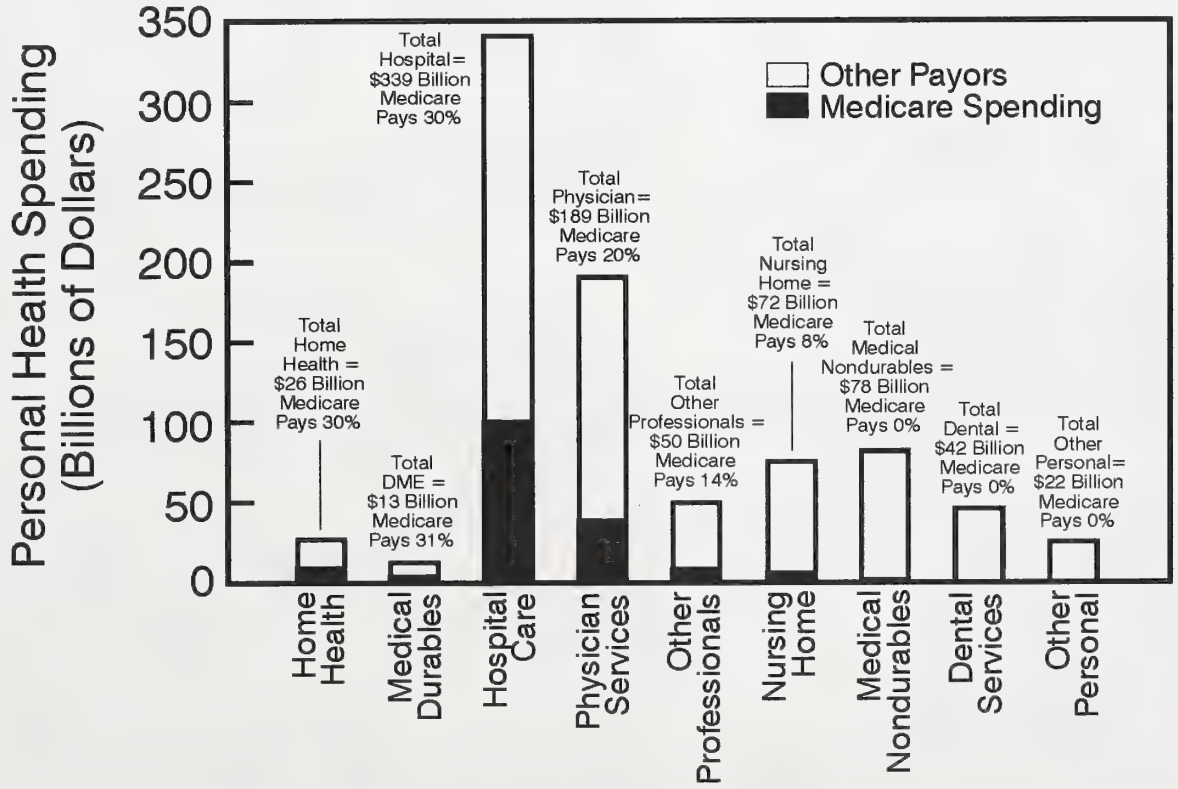
In 1993, elderly Medicare beneficiaries spent an average of $455 a year on outpatient prescription drugs. Despite high levels of supplemental health insurance coverage (Chart H-11), beneficiaries paid 58% of these costs out of pocket (Chart H-14).

- Beneficiaries earning less than $5,000 a year spent significantly less per capita on prescription drugs than other beneficiaries: $389 a year, or about 15% less than the average.

- Out-of-pocket expenses as a percentage of total spending on prescription drugs is relatively stable across different incomes. Beneficiaries earning less than $5,000 a year paid 57% of their prescription drug costs out of pocket, only slightly less than the 60.6% paid by beneficiaries earning more than $50,000 a year.

National Personal Health Expenditures By Type Of Service And Percent Medicare Pays, 1994

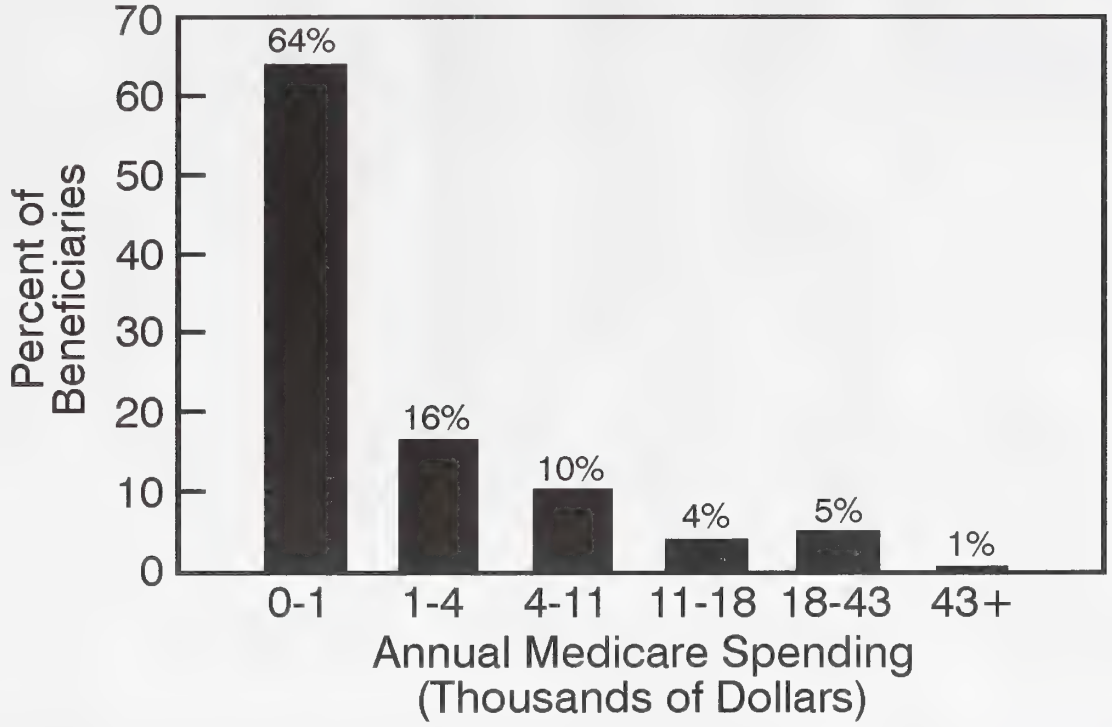
Total National Personal Health Spending In 1994 Was $832 Billion; Medicare Accounted For 20%



Source: HCFA/Office of the Actuary

Distribution Of Medicare Beneficiaries By Annual Program Spending, 1993

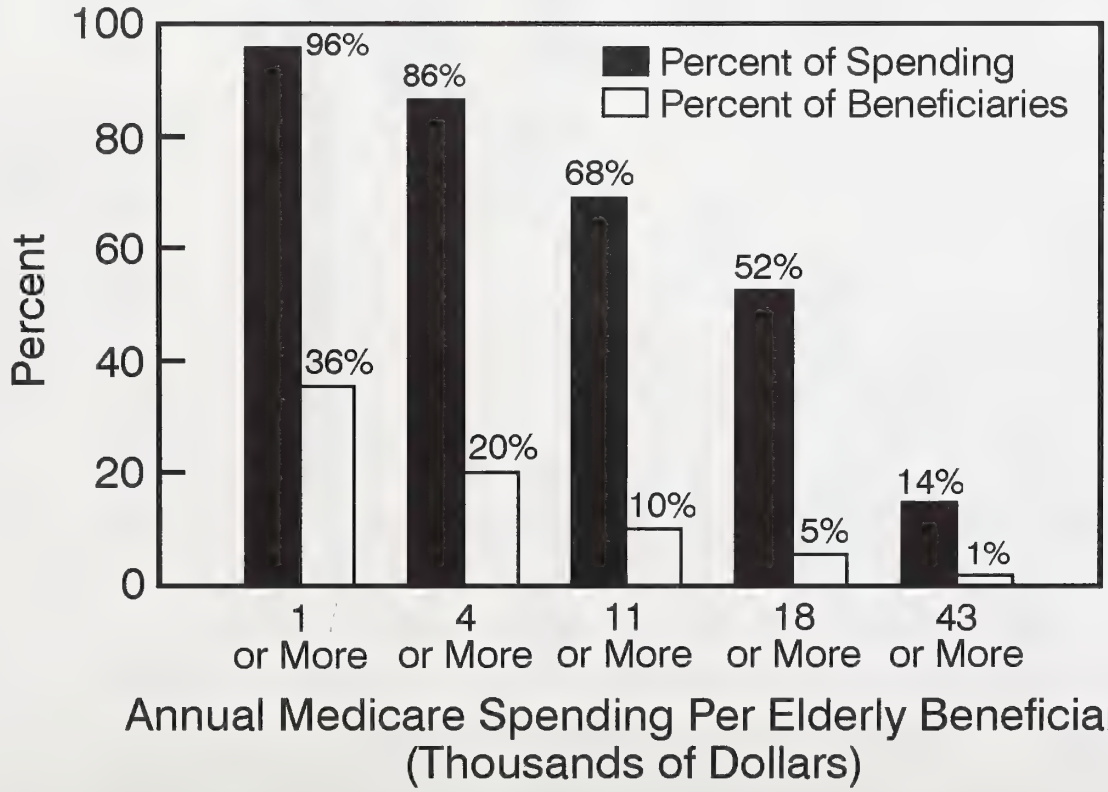
Nearly Two-Thirds Of Beneficiaries Received Medicare Reimbursement Of $1,000 Or Less In 1993



Source: HCFA/Office of the Actuary; data from a 10% sample from 1993 Continuous Medicare History File (does not include HMO enrollees)

Distribution of Medicare Spending For Elderly Beneficiaries, 1993

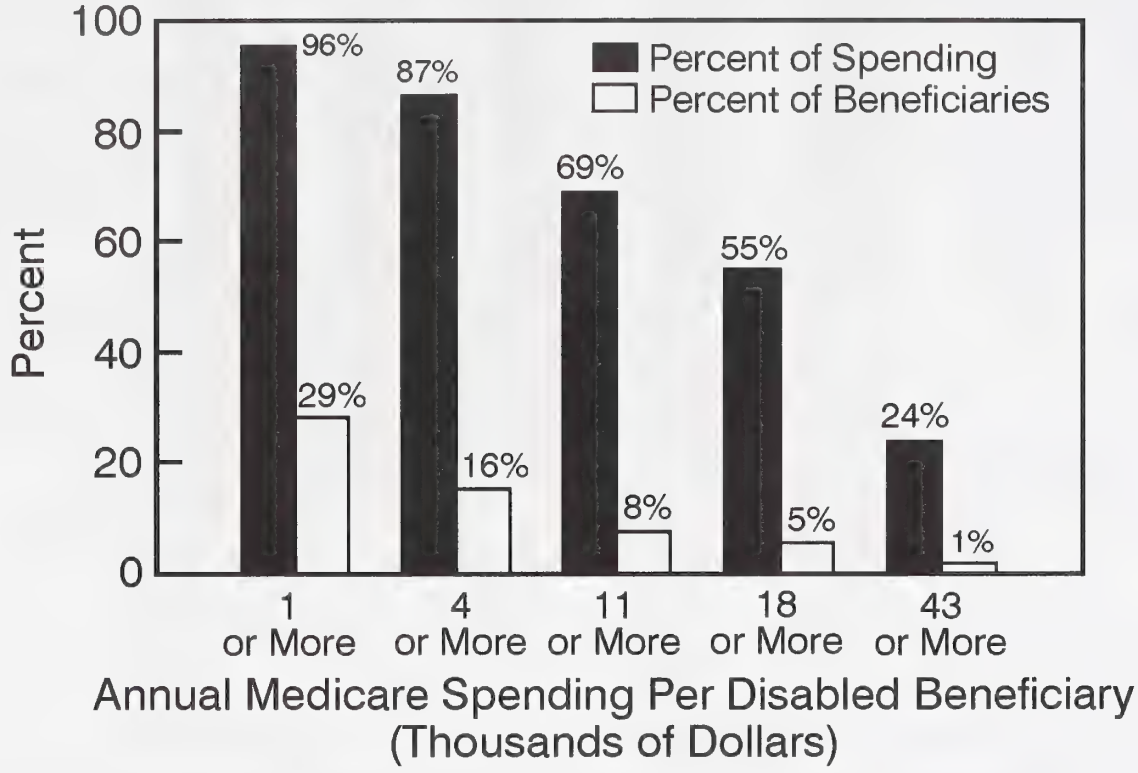
5% Of Beneficiaries Account For 52% Of Spending



Source: HCFA/Office of the Actuary; data from 10% sample from 1993 Continuous Medicare History File (does not include HMO enrollees)

Distribution Of Medicare Spending For Disabled Beneficiaries, 1993

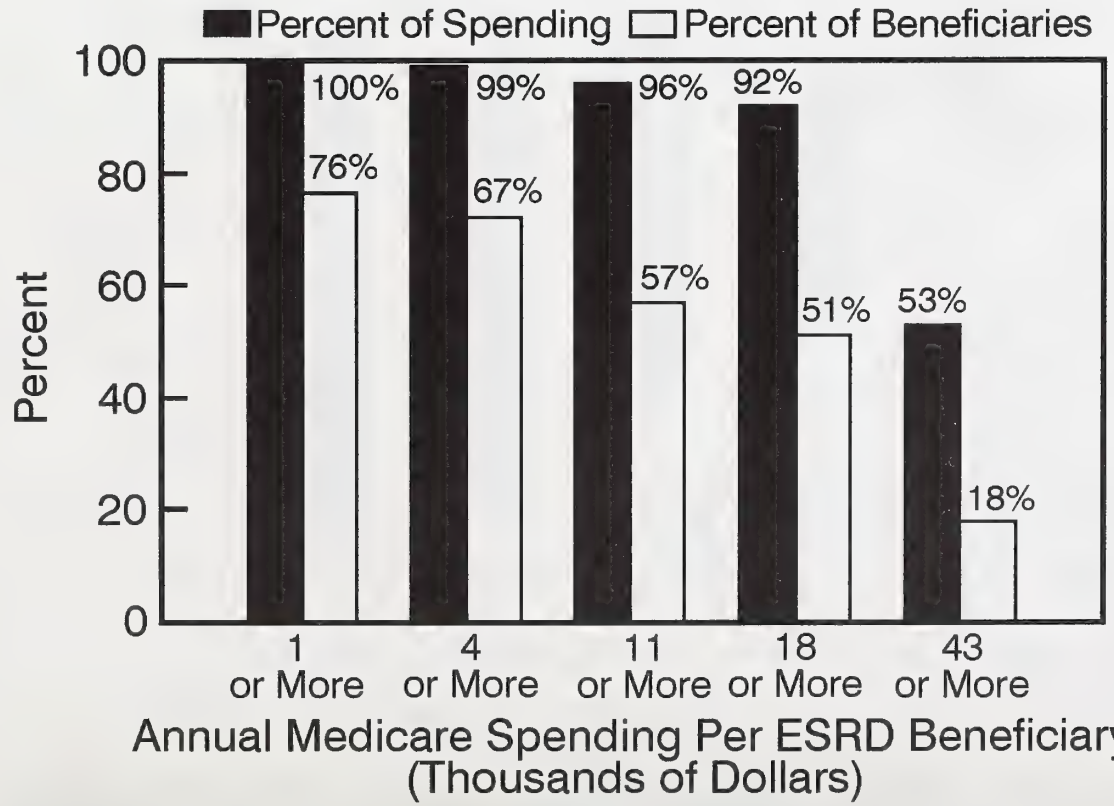
1% Of Beneficiaries Account For 24% Of Spending



Source: HCFA/Office of the Actuary; 10% sample from Medicare Continuous History File (does not include HMO enrollees)

Distribution Of Medicare Spending For Non-Elderly End-Stage Renal Disease Beneficiaries, 1993

Even In A High-Cost Population, Spending Is Concentrated; 18% Of Beneficiaries Account For 53% Of Spending

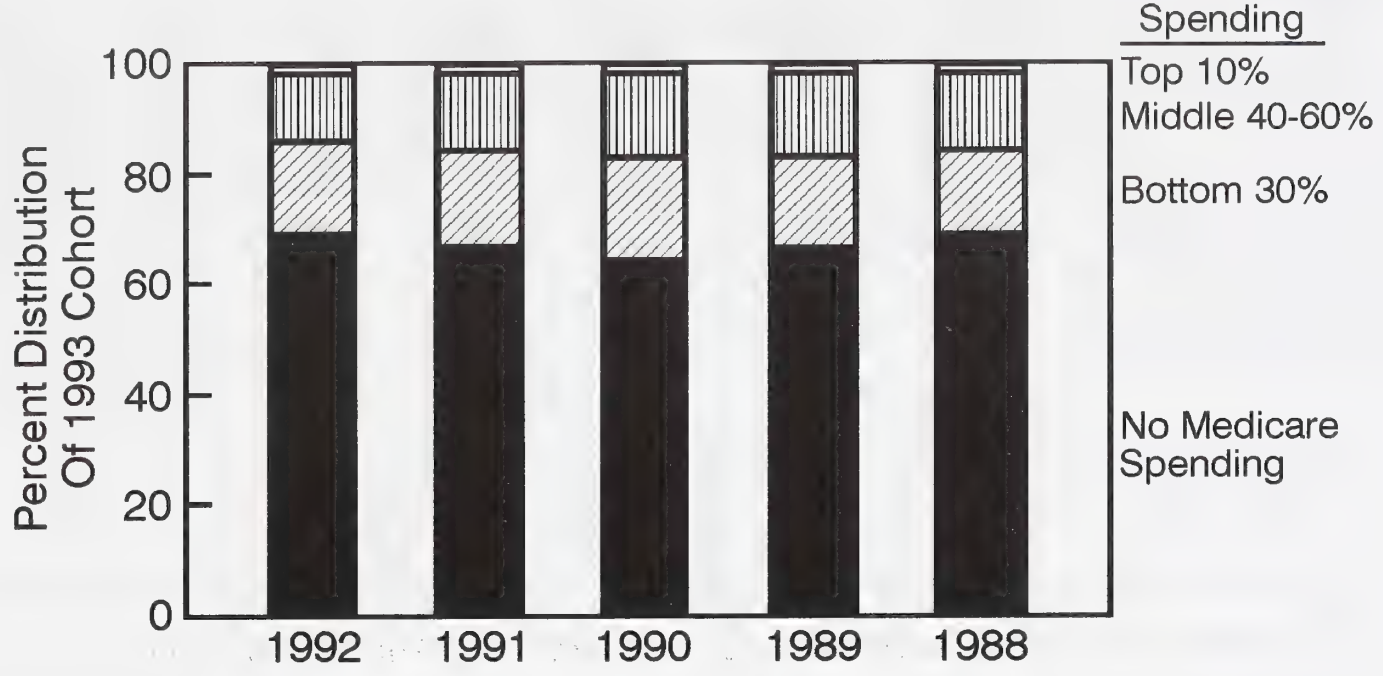


Source: HCFA/Office of the Actuary; data from a 10% sample from Medicare Continuous History file (does not include HMO enrollees)

Medicare Spending In 1988 Through 1992 For Elderly Beneficiaries With No Medicare Spending In 1993

Low Medicare Spending Generally Is Persistent Over Previous Years

A sample (30,462) of elderly beneficiaries with no Medicare spending in 1993...

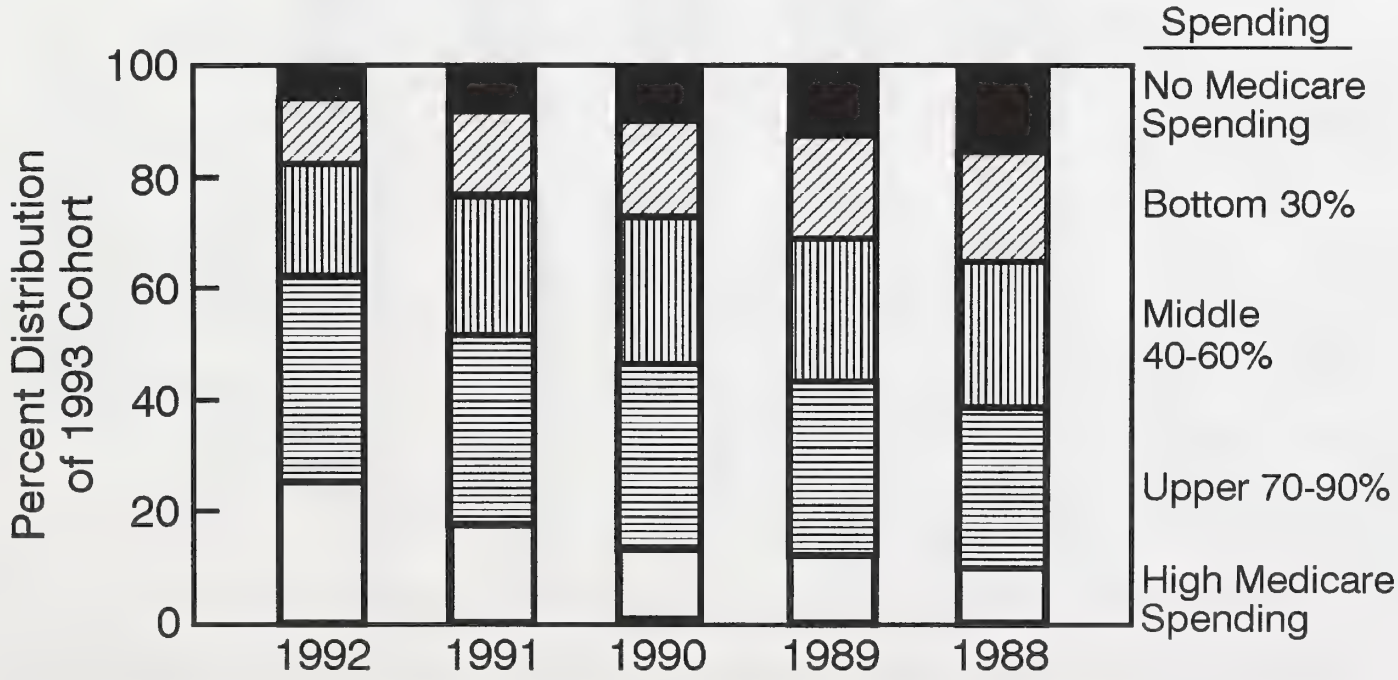


Note: This graph backtracks the experience for the 1993 cohort of people with no Medicare spending who were continously enrolled in Medicare since 1988. A member of that cohort could be in any category of spending over the previous 5 years.
Source: HCFA/Office of the Actuary; data from a 10% sample from Medicare Continuous History file (does not include HMO enrollees)

Medicare Spending In 1988 Through 1992 For Elderly Beneficiaries With High Medicare Spending In 1993

High Medicare Spending Generally Is Not Persistent Over Previous Years

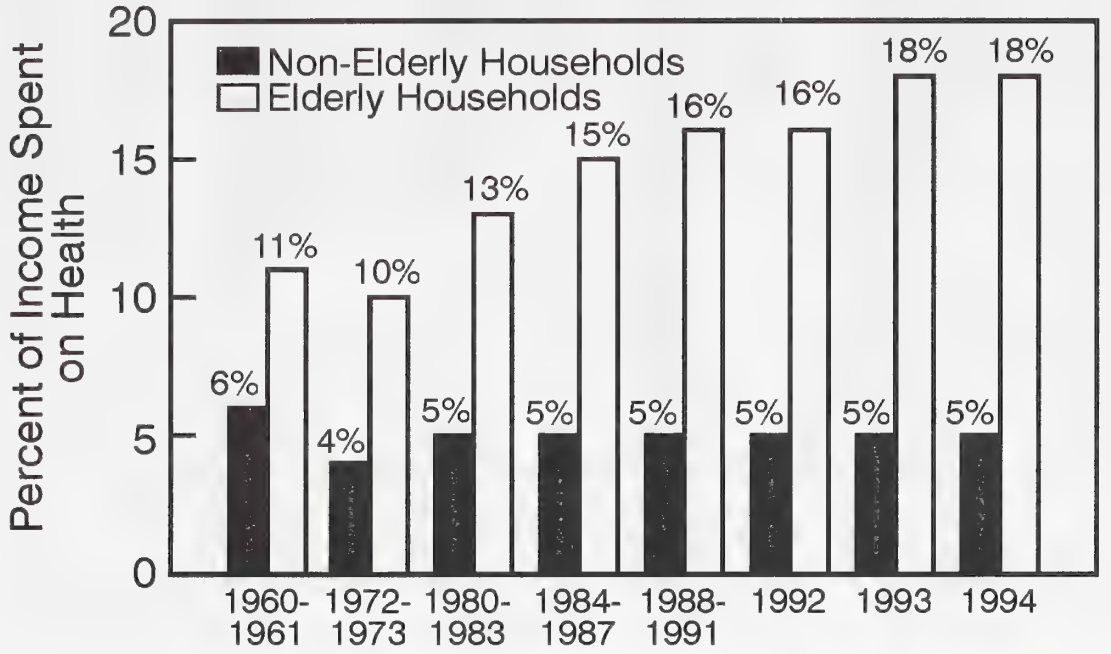
A sample (20,313) of elderly Medicare beneficiaries with high health spending in 1993...



Note: This graph backtracks the experience for the 1993 cohort of people with the highest 10% of spending, who were continously enrolled in Medicare since 1988. Amember of that cohort could be in any category of spending over the previous 5 years.
Source: HCFA/Office of the Actuary; data from a 10% sample from Medicare Continuous History file (does not include HMO enrollees)

Spending For Health As A Percentage Of Income, Elderly And Non-Elderly, 1960-1994*

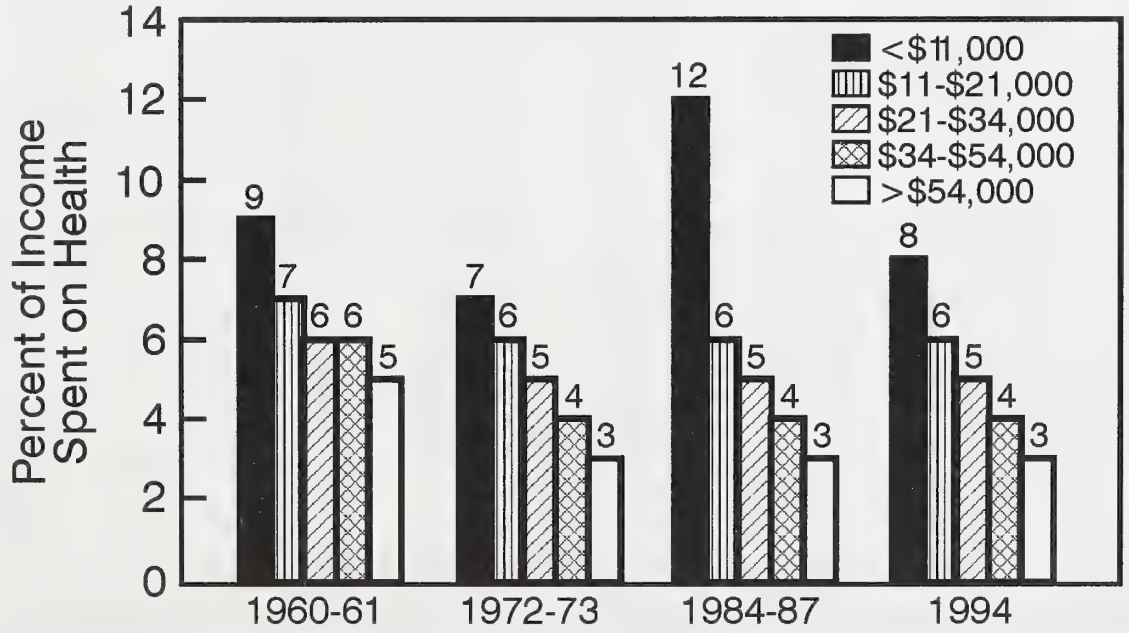
Health Spending Has Absorbed An Increasingly Large Share Of The Elderly's After-Tax Income



*Note: Income is based on total household after-tax income. Households are "consumer units" in which the reference person (e.g., the person whose name is on the mortgage or lease) is under age 65 or age 65 and older, and so may include some people outside the respective age group.
Source: Bureau of Labor Statistics, Consumer Expenditure Survey

Non-Elderly Spending For Health As A Percentage Of Income, By Income Quintiles, 1960-1994

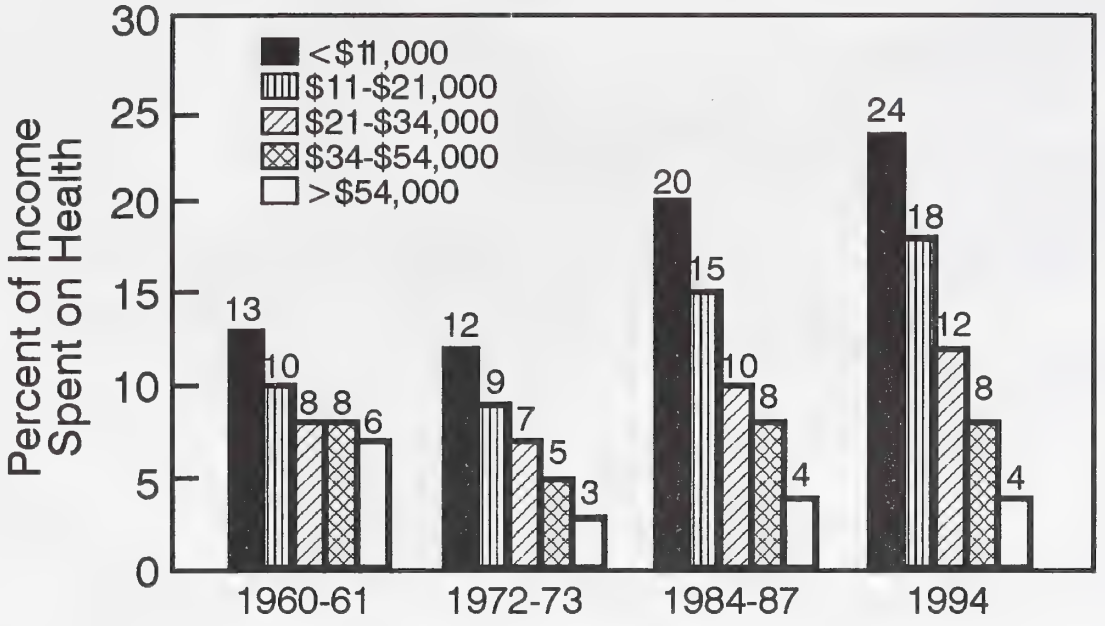
After-Tax Income Has Generally Kept Pace With Changes In Health Spending, With The Poor Spending A Higher Proportion Of Their Income On Health



Note: Income is based on total household after-tax income. Non-elderly households are "consumer units" in which the reference person (e.g., the person whose name is on the mortgage or lease) is under age 65, and so may include some people age 65 or older. To compute quintiles, all consumer units were ranked by income, then split into two age groups (non-elderly and elderly). In 1994, the first quintile included households earning less than $11,000 (16% of non-elderly households); the second quintile, $11,000-$21,000 (17%); the third quintile, $21,000-$34,000 (21%); the fourth quintile, $34,000-$54,000 (23%); and the fifth quintile, more than $54,000 (24%).
Source: Bureau of Labor Statistics, Consumer Expenditure Survey

Elderly Spending For Health As A Percentage Of Income, By Income Quintiles, 1960-1994

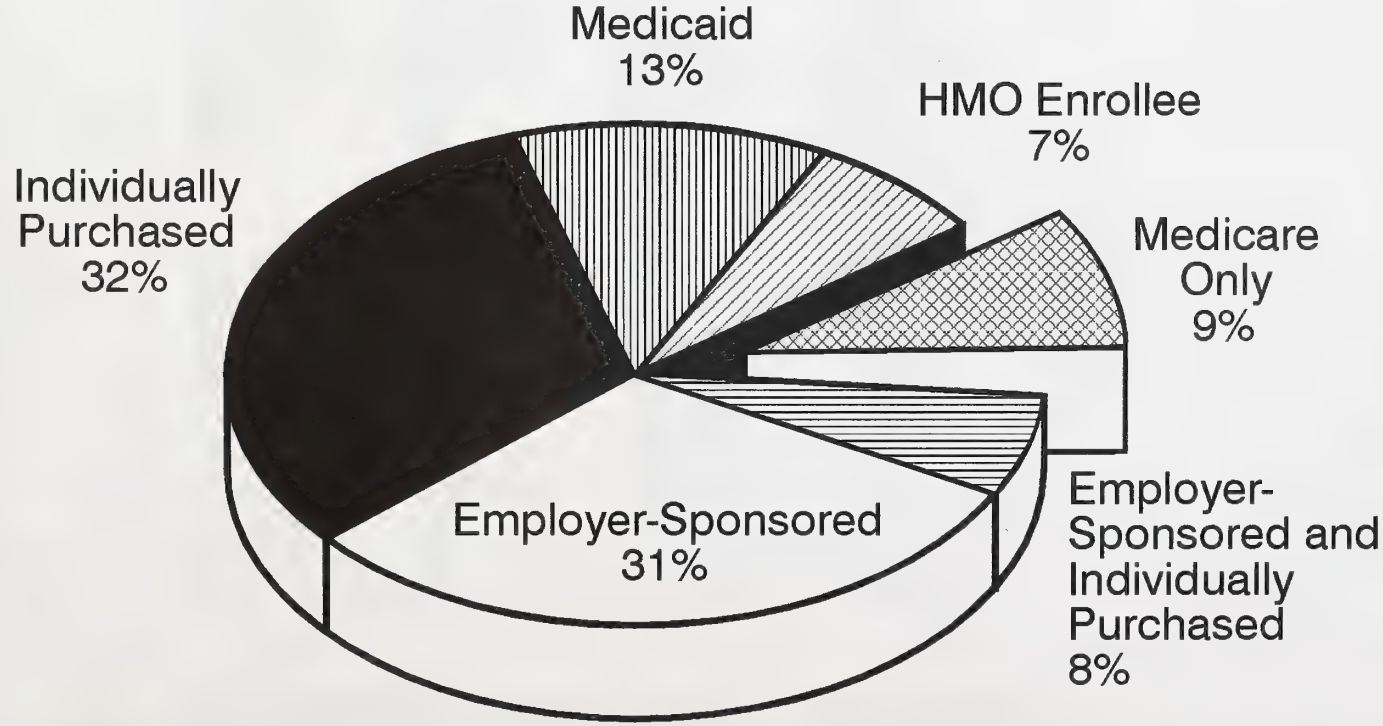
The Elderly Spend A Greater Proportion Of Their Income On Health Than The Non-Elderly. Spending For The Elderly Has Increased As A Percentage Of Income, With The Poor Spending A Greater Proportion Of Their Income On Health



Note: Income is based on total household after-tax income. Elderly households are "consumer units" in which the reference person (e.g., the person whose name is on the mortgage or lease) is age 65 or older and so may include some people under age 65. To compute quintiles, all consumer units were ranked by income, then split into two age groups (non-elderly and elderly). In 1994, the first quintile included households earning less than $11,000 (35% of non-elderly households); the second quintile, $11,000-$21,000 (32%); the third quintile, $21,000-$34,000 (17%); the fourth quintile, $34,000-$54,000 (10%); and the fifth quintile, more than $54,000 (7%).
Source: Bureau of Labor Statistics, Consumer Expenditure Survey

Type Of Supplemental Health Insurance Held By Elderly Medicare Beneficiaries, 1993

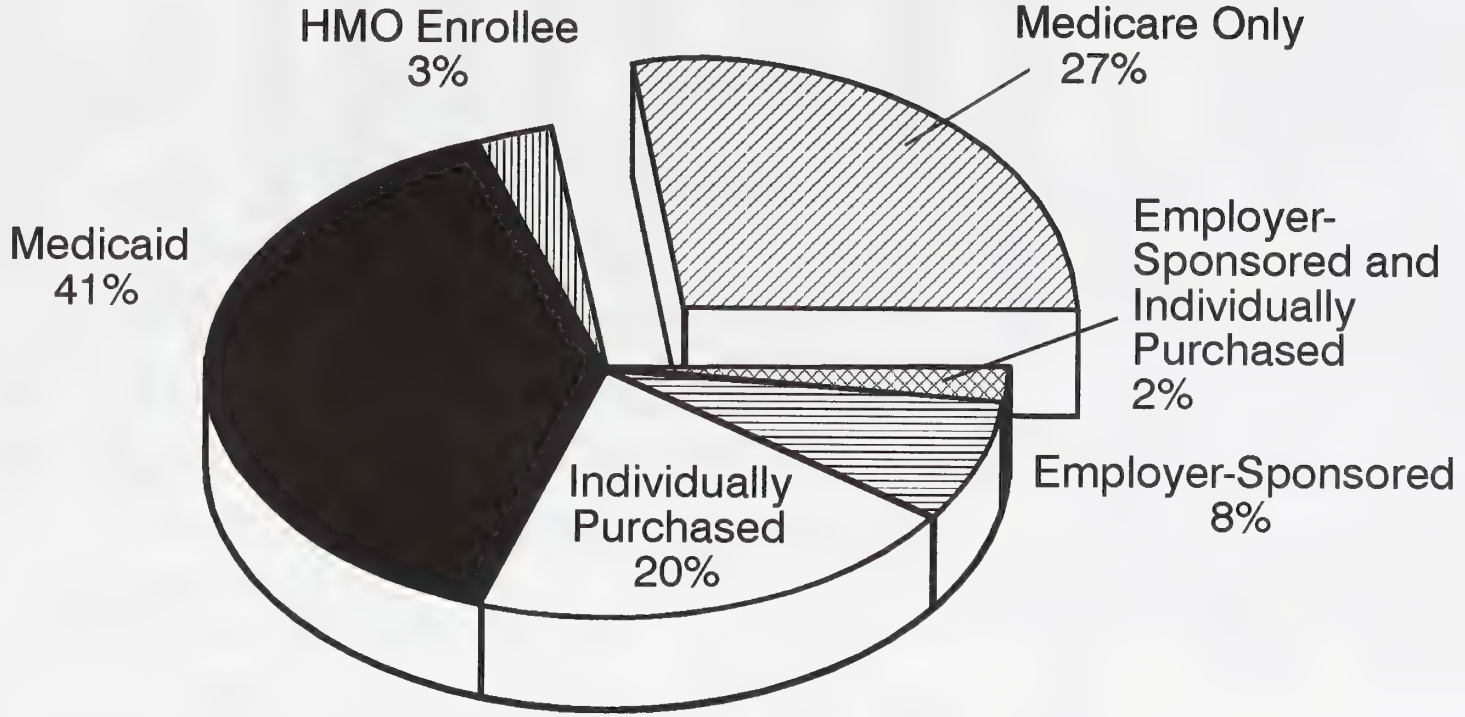
The Vast Majority have Private Insurance, Either Through An Employer Or Purchased Individually



Note: The HMO category includes beneficiaries who enrolled in an HMO any time during 1993.
Source: HCFA/Office of the Actuary; data from the Medicare Current Beneficiary Survey, 1993

Type Of Supplemental Health Insurance Held By Disabled Medicare Beneficiaries, 1993

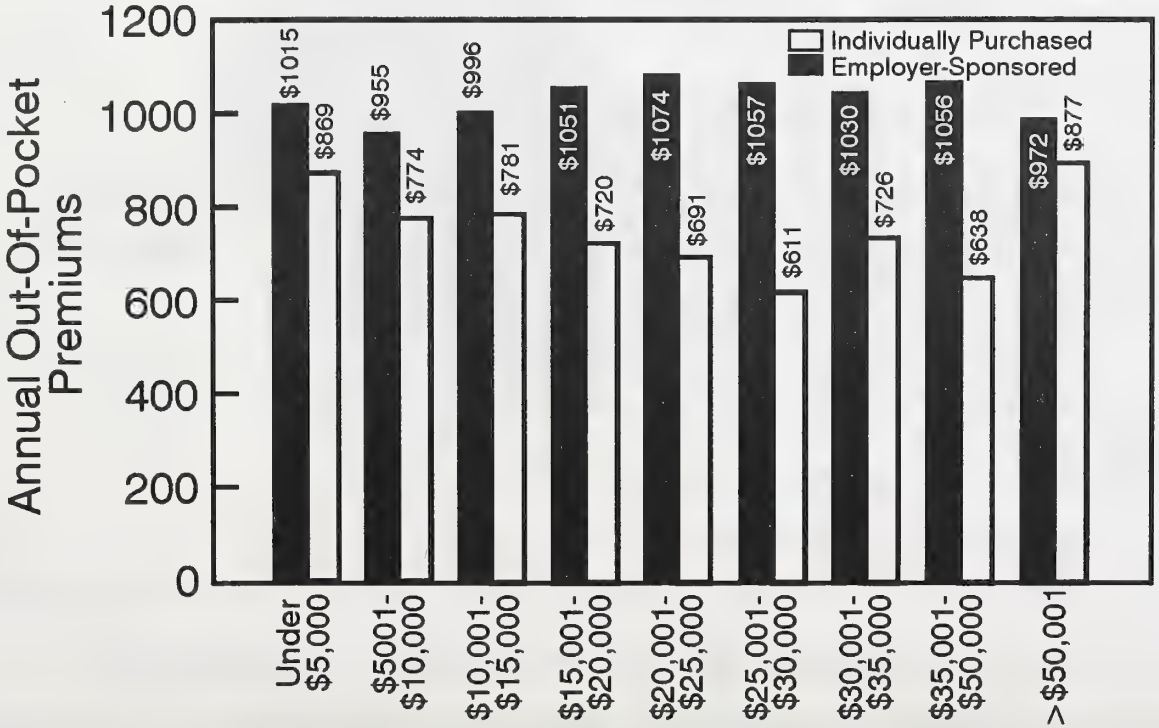
Proportionally More Disabled Beneficiaries Receive Help From Medicaid Or Have No Supplemental Coverage



Note: The HMO category includes beneficiaries who enrolled in an HMO any time during 1993.
Source: HCFA/Office of the Actuary; data from the Medicare Current Beneficiary Survey, 1993

Out-Of-Pocket Premium Payments For Medigap Insurance By Type Of Plan And Income, 1992

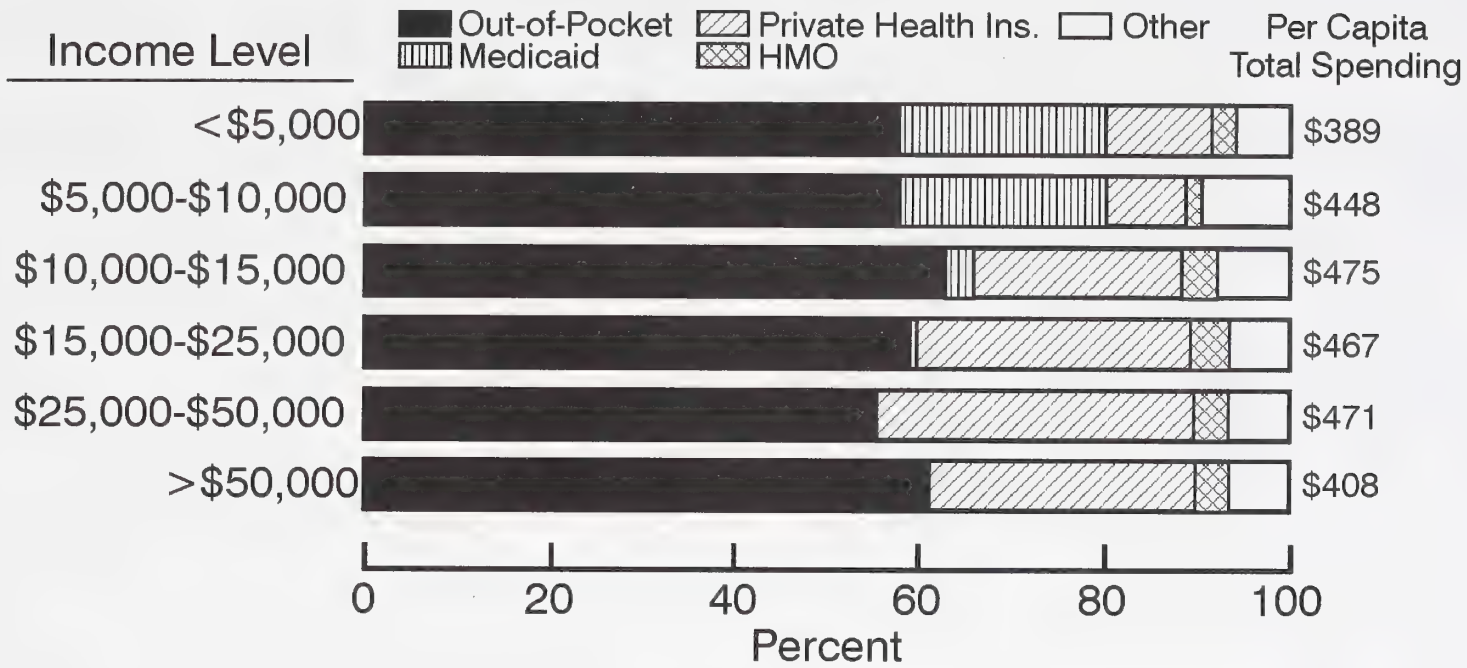
Out-Of-Pocket Premium Costs For Those Covered By Individually Purchased Or Employer-Sponsored Medigap Plans Are Fairly Similar Across Income Levels



Note: Includes all Medicare enrollees who did not enter a long-term care facility during 1992.
Source: HCFA/Office of the Actuary; data from the Medicare Current Beneficiary Survey, 1992.

Source Of Payment For Elderly Medicare Beneficiaries' Prescription Drug Spending, By Income, And Spending Per Capita, 1992

The Percentage Spent Out-Of-Pocket For Prescriptions Is Not Related To Income



Note: Based on beneficiaries living in the community for any part of 1992. "Other" includes VA and DoD pharmacies, other public programs, discounts, and negligible Medicare. Average per capita spending across all beneficiaries totaled $455.
Source: HCFA/Office of the Actuary; data from the Medicare Current Beneficiary Survey, 1992

MEDICARE SPENDING

Program Expenditures: Past, Present, and Future

The share of the nation's income devoted to health care spending has increased significantly in the last 30 years from 6.1% of the gross domestic product (GDP) in 1967 to 13.7% of GDP in 1994.

- Medicare spending has also increased significantly over this time period. In FY 1967, Medicare spent $3.7 billion on health care for approximately 19 million elderly Americans. Today, Medicare serves more than 38 million elderly and disabled beneficiaries and spent approximately $177.1 billion dollars in FY 1995 (Chart MS-1).

- Medicare's coverage of the elderly and disabled, two of the sickest, and therefore high-cost, population groups in the country, results in spending that accounts for a significant portion of overall U.S. health care spending. Per capita, the elderly consume four times the level of health spending as the under 65 population.

- In 1993, Medicare accounted for approximately 19% of personal health care spending in the United States. Due in part to geographic variation in the elderly population, Medicare's contribution to personal health care spending varies considerably by state, from about 6% in Alaska to more than 27% in Florida (Note: 1993 is most recent year that state data was available (Chart MS-2).

- Elderly beneficiaries will account for about 87% of Medicare spending in 1996, while disabled beneficiaries will account for nearly 13% of Medicare expenditures. Reflecting their growing share of the Medicare population, disabled beneficiaries' share of Medicare spending, however, is expected to increase in the next decade to nearly 16% by 2005 (Chart MS-3).

Hospital spending: Since Medicare's implementation, hospital services have accounted for the largest portion of Medicare payments.

Medicare began with the goal of helping beneficiaries pay for acute care--the most expensive of these being inpatient hospital and physician services. Since Medicare's implementation, hospital services have accounted for the largest portion of Medicare payments.

- In FY 1967, Medicare payments for inpatient hospital services were $2.6 billion; by FY 1995, that had increased to $87.7 billion. However, the inpatient hospital share of Medicare spending is shrinking as medical care is shifting more towards the outpatient setting.

Since the mid-1980s, the rate of increase in spending for hospital inpatient services has slowed significantly. In the first two decades of the program, Medicare reimbursed hospitals retrospectively, based on the "reasonable cost" of providing a service. This methodology changed in 1984, when the prospective payment system (PPS) was implemented. Because payments were tied to costs, the reasonable cost system did not provide hospitals incentives to provide care efficiently. PPS helps create such incentives by paying hospitals a pre-determined rate for each patient based on their diagnosis. PPS has had a profound effect on trends in inpatient and outpatient use.

- The average annual growth rate for inpatient hospital expenditures was 14.7% from 1980-85. Between 1985 and 1990, PPS slowed expenditures for inpatient hospital services to 5.6% annually. In the period 1990-95, annual growth rates averaged 8.1% (Chart MS-4).

Physician spending: The average annual growth rate for physician services is growing more slowly than it did in the past.

- Between 1990 and 1995, expenditures for physician services grew on average 8.2% annually compared to 13.8% annually in the prior five-year period, and 16.4% per year from 1980-1985. The Medicare physician fee schedule, implemented in 1992, is largely responsible for slowed growth rates.

Other providers: While growth in inpatient hospital and physician expenditures is slowing, expenditures for other providers are growing rapidly.

- Annual growth in spending for home health and skilled nursing facility care has risen especially rapidly as coverage for these benefits was liberalized and the number of providers participating in the Medicare program increased.

- Between 1990 and 1995, expenditures for home health services increased by 34.8% annually while skilled nursing facility spending grew by 26.5% each year during the same period. Annual spending increased for hospital outpatient services an average of 11.6% between 1990 and 1995 (Chart MS-4).

- The number of home health agencies and skilled nursing facility beds increased 42% and 34%, respectively, between 1990 and 1993 (Chart MS-5).

- Medicare utilization rates also reflect the shift of medical care toward outpatient settings. During the period 1980-1993, the number of days of hospital care per 1,000 beneficiaries decreased by approximately 3.4% annually. Home health agency visits per 1,000 beneficiaries increased by 17.7% annually. Skilled nursing facility days of covered care increased by approximately 9.3% annually from 1980-1993 (Chart MS-6).

- The result is a significant shift in spending by type of service: Inpatient hospital payments represented two-thirds of Medicare spending in 1980 and less than half of total Medicare expenditures in 1995. In 1980, payments for hospital outpatient services represented 5.5% of Medicare expenditures. The percentage of Medicare expenditures for hospital outpatient services reached 8.2% by 1995. Skilled nursing facilities' share of program spending increased from 1.2% of the total in 1980 to 5.2% in 1995. Home health payments represented 2.2% of the total in 1980 and 8.5% in 1995 (Chart MS-7).

Medicare Compared to Private Insurers: Rates of Growth

Between 1969 and 1993, the rate of increase in Medicare and private health insurance spending was comparable.

- Medicare expenditures grew on average 13.7% annually while expenditures for private health insurance increased 13.4% annually from 1969-1993. Some years, Medicare grew more rapidly than private insurance, other years, the situation reversed. In 1994, Medicare spending increased 11.8% while private health insurance expenditures increased 4%.

It is problematic to compare overall growth in Medicare spending with growth in private insurance spending because enrollment growth has differed substantially between Medicare and private plans.

- Medicare enrollment has been increasing at an average annual rate of 2.5% per year since 1969 and 1.9% since 1991. Enrollment in private health insurance grew more slowly, averaging 0.7% annually since 1969. In recent years, however, enrollment in private health insurance

plans has actually declined by 0.3% annually since 1991. Therefore, one would expect Medicare expenditures to grow in the aggregate more rapidly than private health insurance benefits.

- On a per enrollee basis, Medicare spending grew, on average, 10.9% annually between 1969 and 1994. Private health insurance per enrollee spending grew, on average 12.2% annually during the same period. From 1993-1994, Medicare per enrollee spending grew 9.8% compared to 4.1% for private insurance.

Differences in benefit packages also make it difficult to compare Medicare and private health insurance expenditure growth.

- Medicare helps pay for health care services for the elderly and disabled populations while private health insurance primarily pays for health care for the working-age population and their families. The health care services covered by these programs reflect the different needs of these populations. For example, Medicare pays for more home health services and skilled nursing facility care than private insurance, private insurance benefit packages can include coverage for prescription drugs and dental services, benefits that Medicare does not cover.

- Government regulations influence spending growth. Medicare's spending increase in 1994 was exaggerated by two aspects of Medicare Volume Performance Standards (MVPS). The bonus earned by physicians and other professionals in 1992 was paid in 1994, and excessive volume increases boosted spending in 1994, but will be offset by penalties in 1996. By associating bonuses and penalties with the year in which they occurred, the 1994 growth in Medicare spending more accurately measures the ultimate obligations incurred by the program in 1994. MVPS effects accounted for 10% of Medicare's 1994 growth.

- A meaningful analysis of Medicare and private insurance would remove the differences associated with enrollment changes, coverage differences, and the effects of the MVPS. Adjusting for these factors, Medicare expenditures grew 5.6% on a per enrollee basis from 1993-1994. Private health insurance per enrollee expenditures grew 3.6% during the same period.

Medicare Compared to Private Insurers: Payment Rates

Medicare payment rates have been consistently lower than private payers' rates.

- For hospital services, Medicare paid approximately 96.9% of **costs** in 1994 while private payers paid 124.4% of **costs**. Both Medicare and private payers paid a higher percent of costs that year compared to the previous year. (Chart MS-10).

- Medicare also pays less for physician services than private insurers. Unlike hospitals, where the relative percentage of **costs** are measured, for physician services, the percentage of **fees** are measured. On average, Medicare **fees** were approximately 66% of private insurance payment amounts in 1994. This percentage is slightly higher than in the early 1990s when Medicare physician payment reform tightly restricted payment increases. Higher Medicare updates, along with lower inflation in the private sector have begun to narrow the gap[1] (Chart MS-11).

[1]Physician Payment Review Commission Annual Report, 1996.

Medicare Compared to Private Insurers: Administrative Costs

Medicare's administrative costs are also lower than those of private insurers.

- Medicare's administrative costs are less than 2% of the total cost of the program compared to 9.5 % for all private insurance and 11.9% for HMOs. Private insurance administrative costs include marketing, profit, and other costs not borne by Medicare (Chart MS-12).

- Medicare administrative costs have been declining, reflecting greater efficiency through economies of scale and high levels of automated claims processing.

- Contractors process a large and growing volume of Medicare claims and bills each year. In 1995, the total was approximately 784.4 million. In contrast, there were approximately 19.1 million Medicare claims and bills processed in 1967 (Chart MS-13).

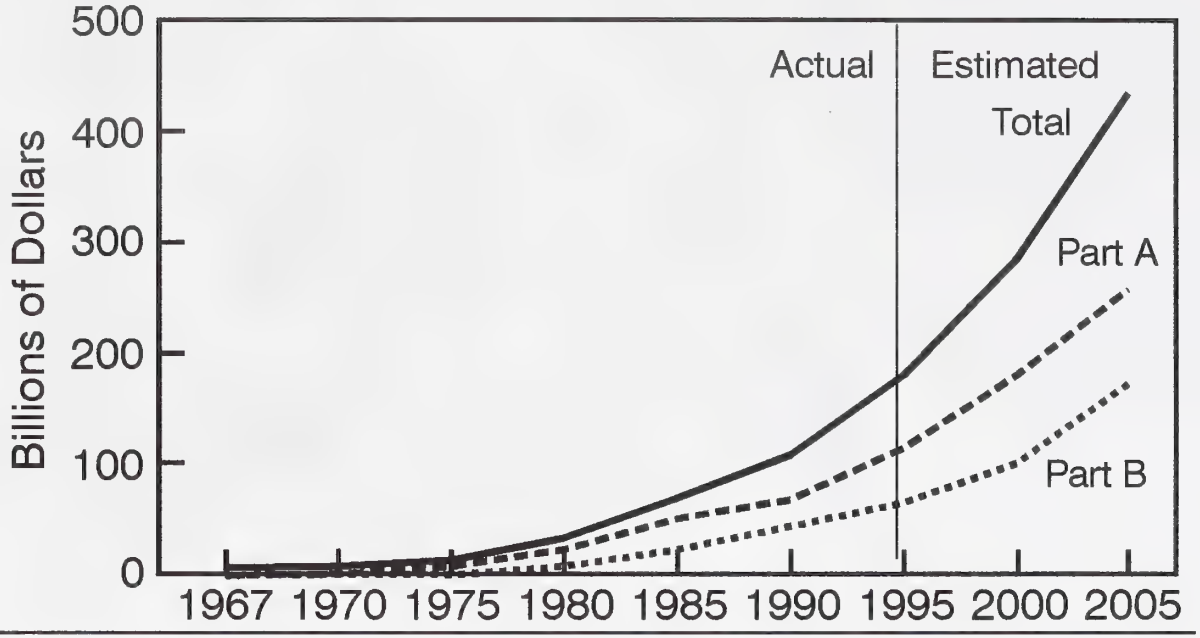
- Today, over 95% of Medicare hospital and skilled nursing facility claims and 75% of Medicare physician, laboratory, and durable medical equipment claims are submitted electronically (Chart MS-14).

- In 1975, it cost Medicare $3.84 to process each hospital and skilled nursing facility claim. Medicare paid $2.90 per physician/supplier claim the same year (Chart MS-15).

- In 1994, Medicare's cost to process claims fell to $1.51 for each hospital and skilled nursing facility claim and $1.21 for each physician/supplier claim (Chart MS-15).

Medicare Spending, 1967-2005

Medicare Spending Has Grown From Less Than $4 Billion In 1967 To Over $177 Billion In 1995

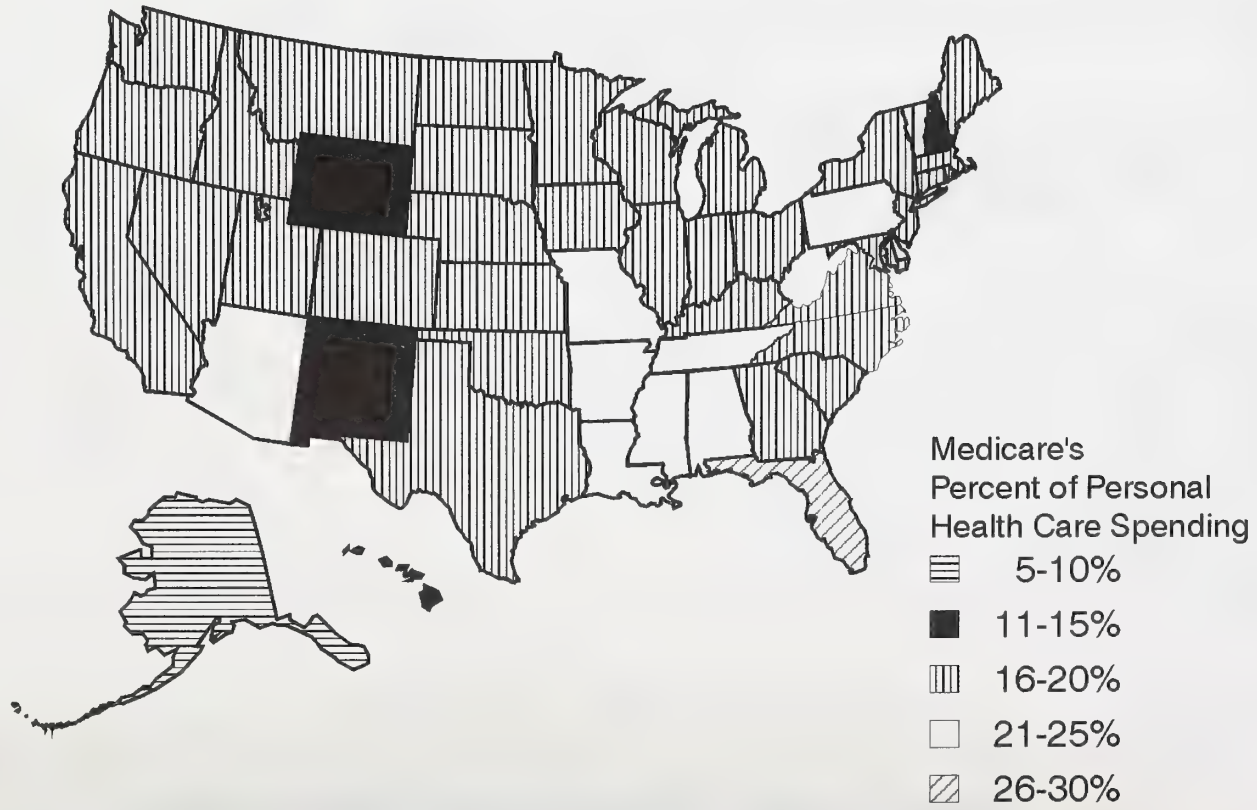


	1967	1970	1975	1980	1985	1990	1995	2000	2005
Part A ----	2.8	4.7	10.8	23.8	47.8	65.9	113.6	175.0	251.3
Part B	0.9	1.9	4.1	10.1	21.3	41.3	63.5	102.1	169.4
Total (In Billions) ——	3.7	6.9	14.9	33.9	69.1	107.2	177.1	277.1	420.8

Note: Fiscal year data. Data for 2000 and 2005 are estimated.
Source: HCFA/Office of the Actuary, 1996.

Medicare's Share Of Personal Health Spending, By State, 1993

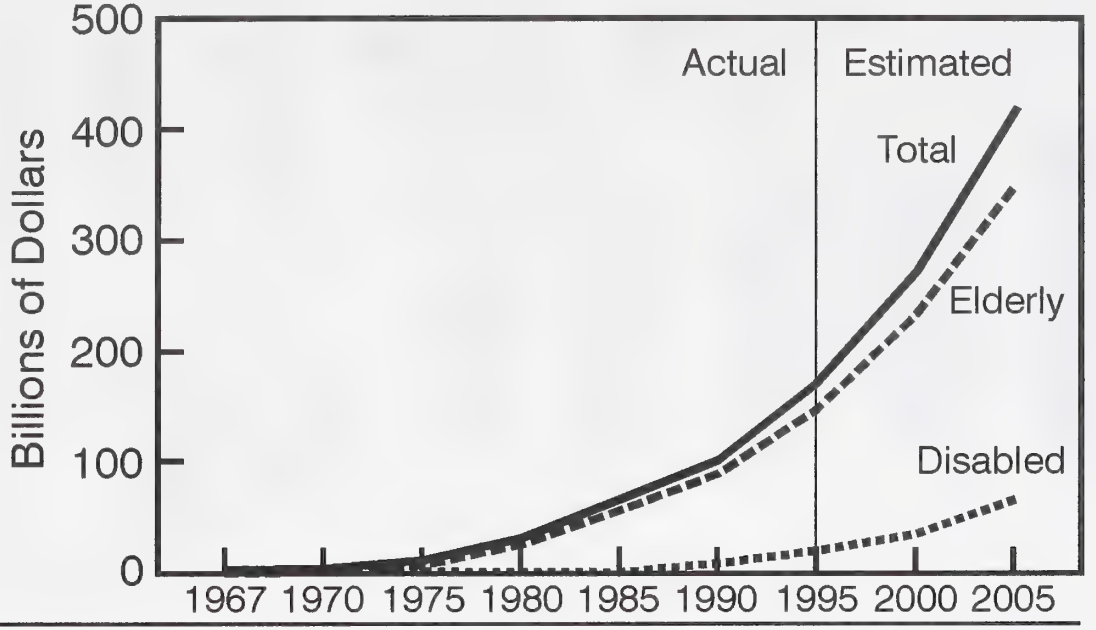
Medicare's Share Of State Health Spending Varies Significantly



Source: HCFA /Office of the Actuary, 1996

Medicare Spending For Elderly And Disabled Beneficiaries, 1967-2005

Disabled Beneficiaries' Share Of Medicare Spending Is Growing

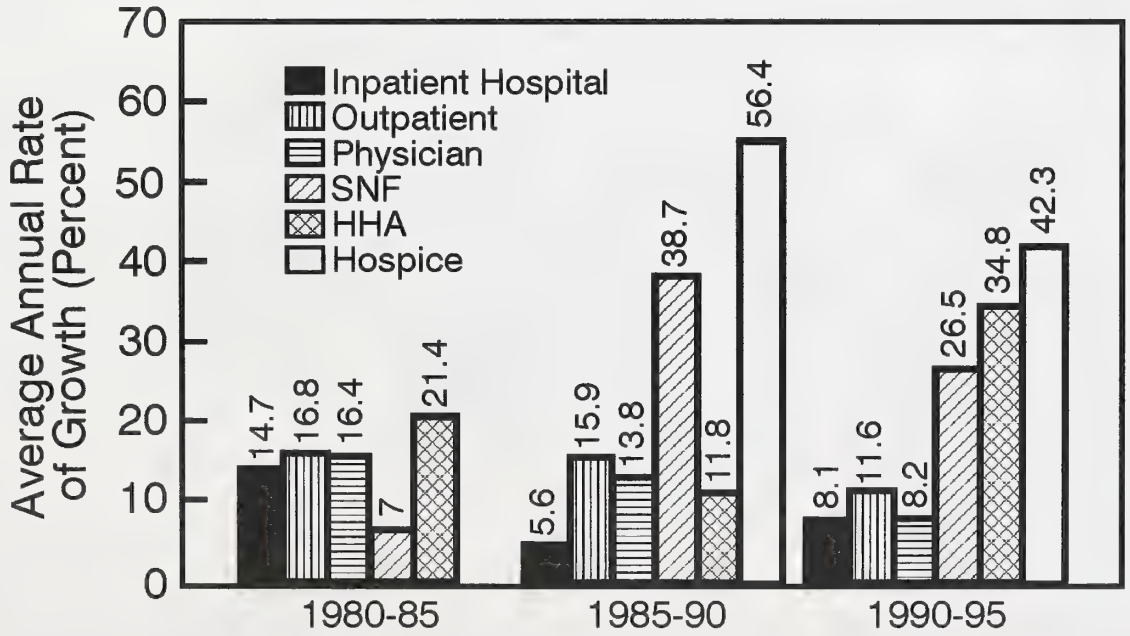


	1967	1970	1975	1980	1985	1990	1995	2000	2005
Elderly ----	3.7	6.9	14.3	29.5	61.0	95.2	154.8	237.8	354.3
Disabled			1.8	4.4	8.1	12.0	22.3	39.3	66.5
Total (In Billions) ———	3.7	6.9	14.9	33.9	69.1	107.2	177.1	277.1	420.8
Share of Disabled in Total	$0.0	0%	10.2%	13%	11.7%	11.2%	12.6%	14.2%	15.8%

Note: Fiscal year data. Data for 2000 and 2005 are estimated.
Source: HCFA/Office of the Actuary, 1996.

Five-Year Average Annual Medicare Growth Rates, 1980-1995

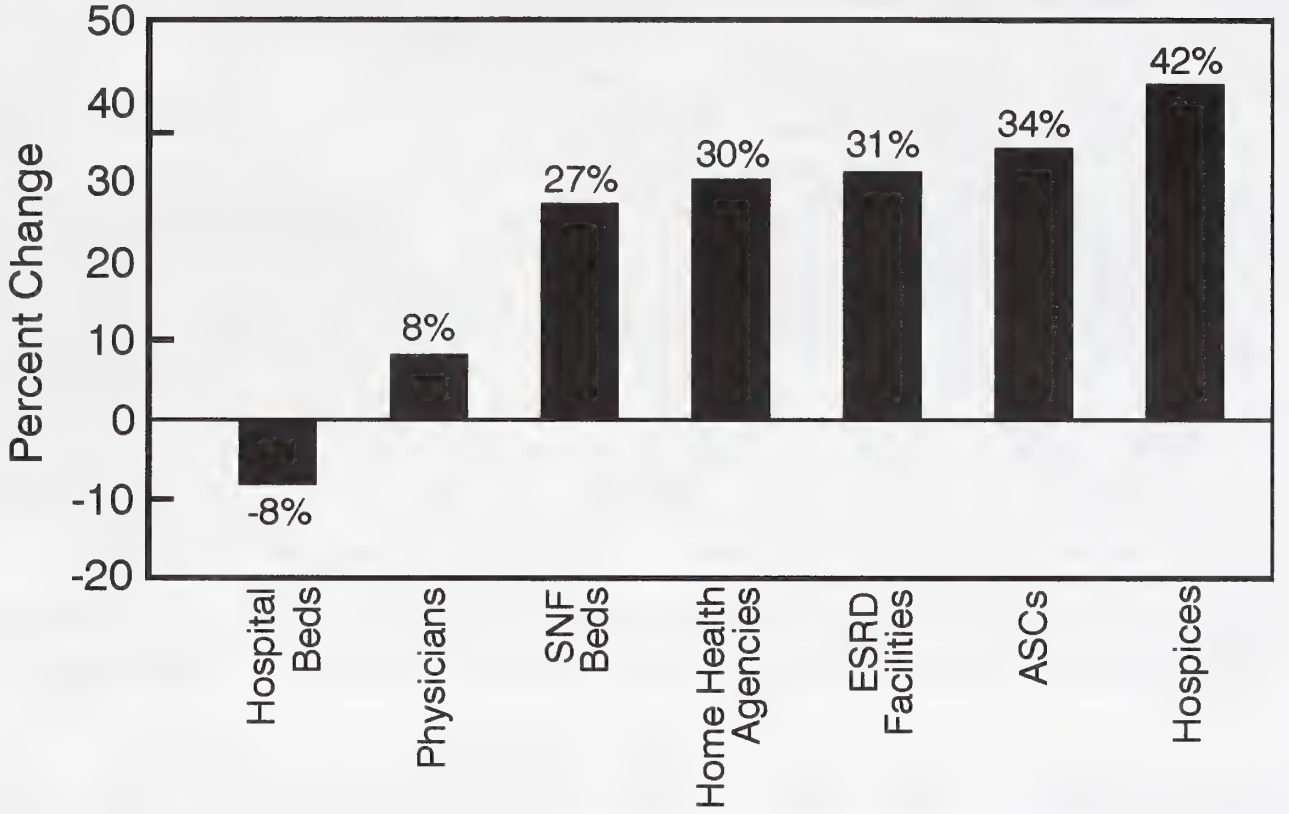
Expenditures For SNFs, HHAs, And Hospices Are Growing Faster Than Expenditures For Other Providers



Note: Fiscal year data.
Source: HCFA/Office of the Actuary, 1996

Provider Change In Capacity, 1990-1993

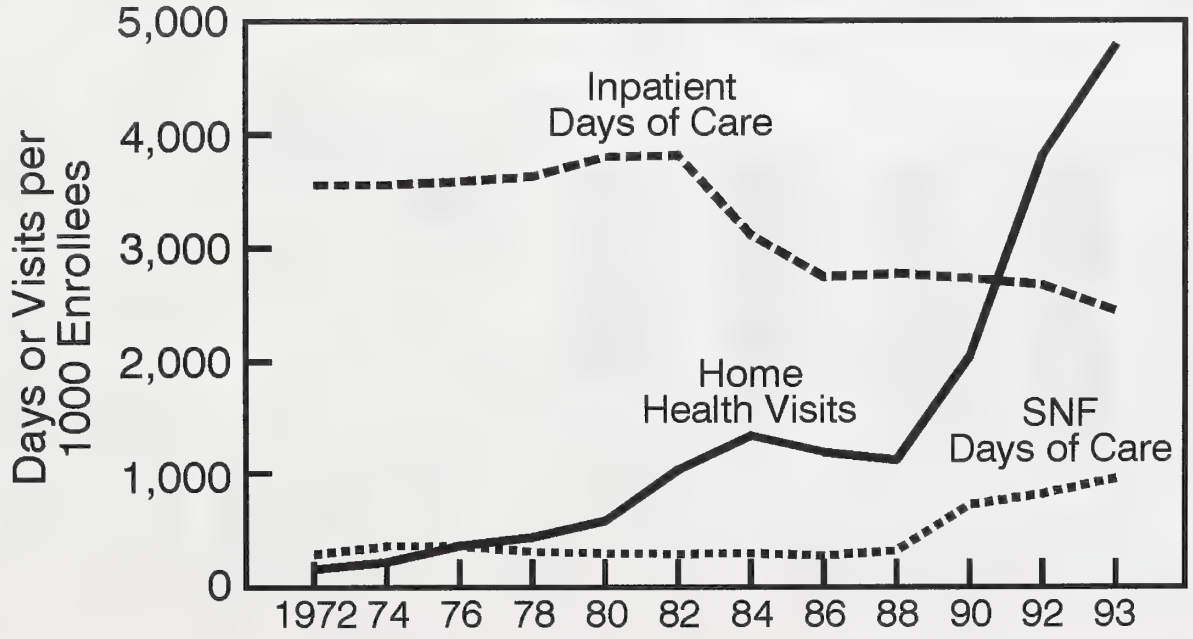
The Growth In SNF, Home Health, And Hospice Providers Reflects The Shift Toward Outpatient Care



Source: HCFA/Bureau of Data Management and Strategy

Medicare Beneficiary Utilization, Services Per 1,000 Enrollees, 1972-1993

While The Number Of Inpatient Hospital Days Of Care Are Decreasing, Skilled Nursing Facility And Home Health Agency Services Are Growing

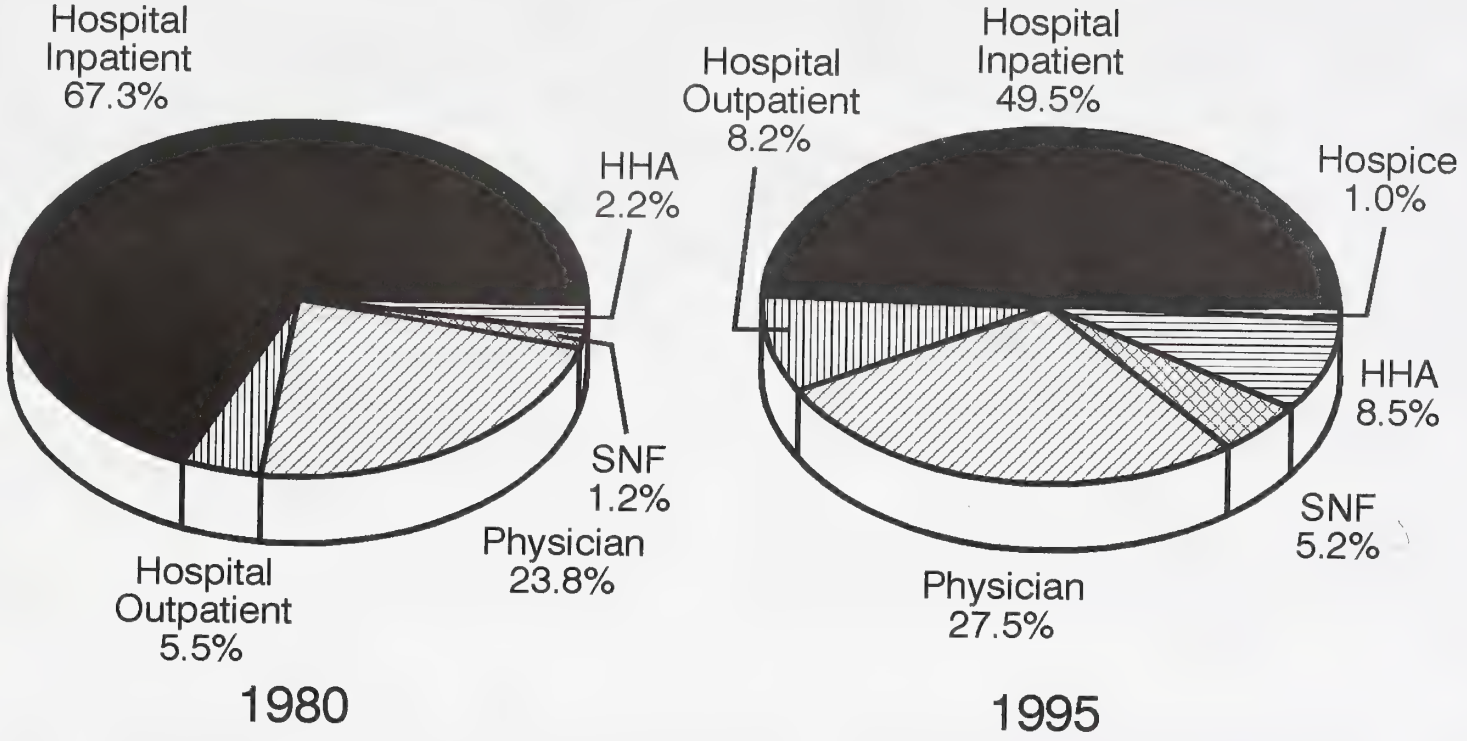


	1972	74	76	78	80	82	84	86	88	90	92	93
Inpatient Hospital (Days of Care)	3,656	3,658	3,693	3,711	3,890	3,889	3,217	2,784	2,804	2,749	2,642	2,474
Skilled Nursing Facility (Days of Care)	314	374	386	334	308	303	321	261	329	747	824	0,959
Home Health Visits	174	232	373	469	582	1,054	1,348	1,217	1,146	2,062	3,835	4,842

Source: HCFA/Office of the Actuary, Bureau of Data Management and Strategy.

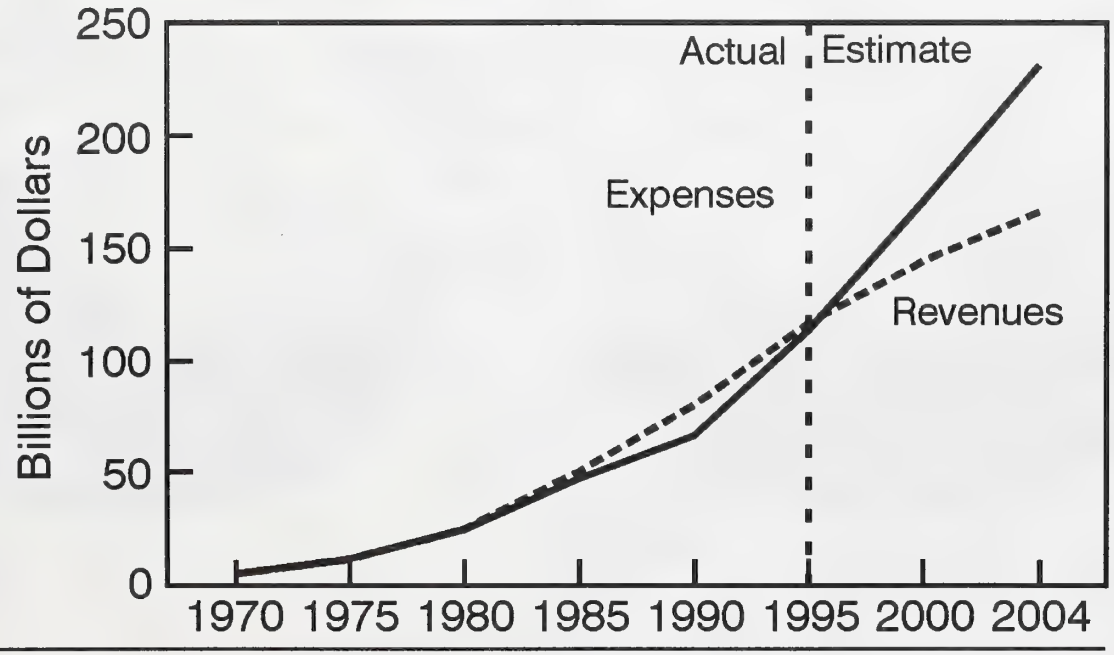
Where The Medicare Dollar Went, 1980 And 1995

Medicare Expenditures Are Shifting Away From Inpatient Hospitals Toward Other Providers



Source: HCFA/Office of the Actuary, 1996

Solvency Of The Medicare Part A Trust Fund

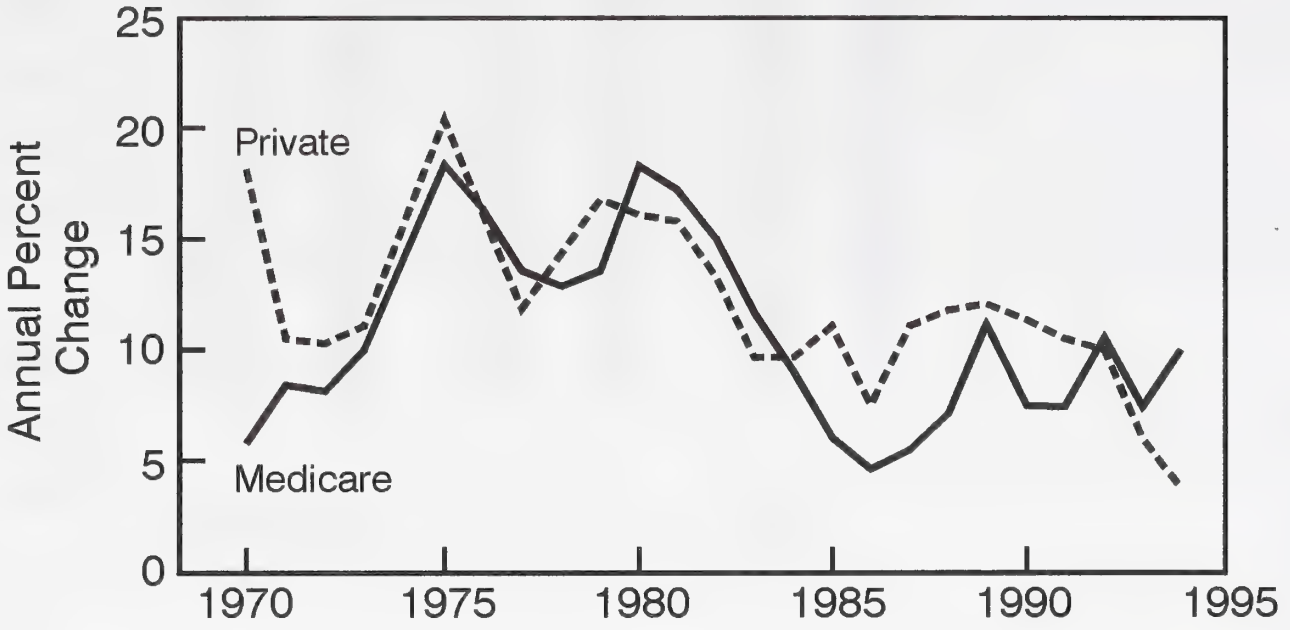


	1970	1975	1980	1985	1990	1995	2000	2004
Revenues ($) ----	6.0	13.0	26.1	51.4	80.4	117.4	144.5	166.3
Expenses ($) ——	5.3	11.6	25.6	48.4	67.0	113.9	170.8	231.4

Note: In the spring of 1995, the Medicare trustees estimated that Part A spending would surpass trust fund revenues in 1996. The shortfall actually came in 1995, one year earlier than expected.
Source: Medicare Trustees Report, 1995. Revenues and expenses for 1995, 2000 and 2004 are intermediate estimates of the Medicare Trustees

Growth In Medicare And Private Health Insurance, Spending Per Enrollee, 1970-1994

Medicare And Private Insurance Spending Have Exhibited Similar Patterns Over Time

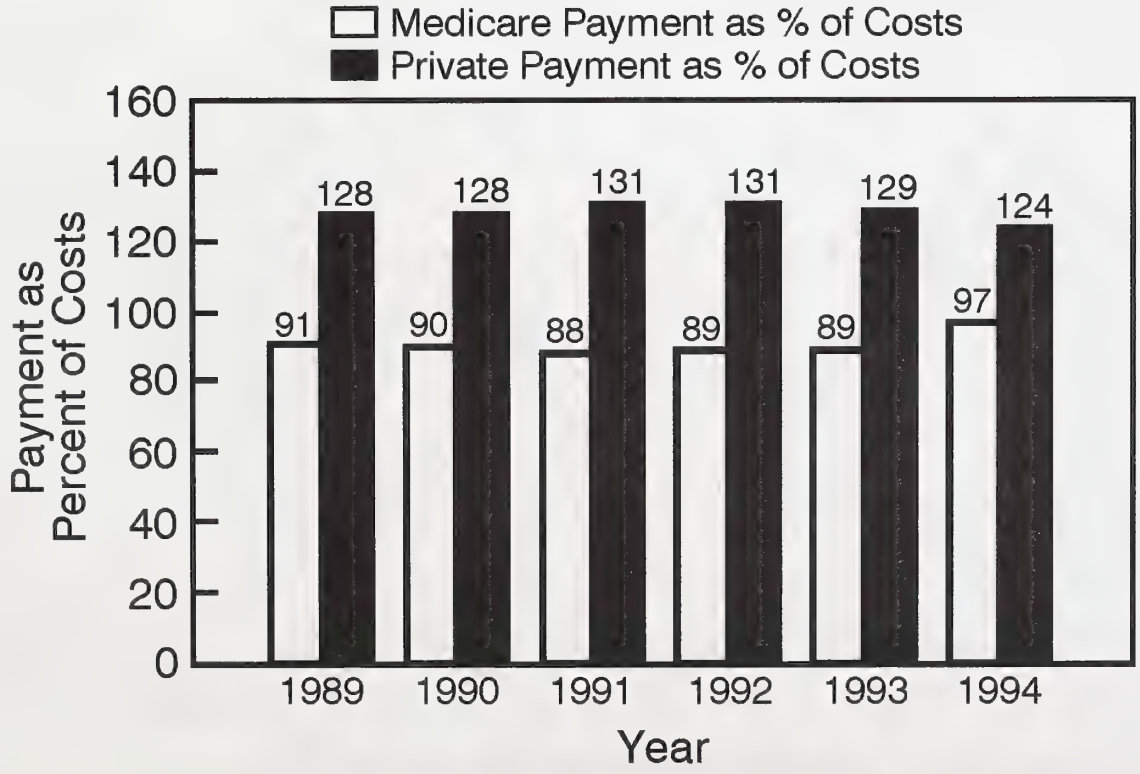


Medicare	6.3	8.5	8.2	10.4	14.8	18.7	16.5	13.7	12.9	13.6	18.6	17.5	15.4	12.0	9.4	6.2	4.7	5.4	7.1	11.3	7.6	7.5	10.7	7.3	9.8
Private Health Insurance	17.4	10.3	10.3	11.1	14.9	20.7	16.8	11.9	14.4	17.0	16.3	16.1	13.7	9.8	9.6	11.2	7.5	11.1	11.9	12.2	11.5	10.5	10.2	6.2	4.1

Note: On a per enrollee basis, private health insurance grew on average 12.2% annually between 1969 and 1994, compared to 10.9% for Medicare.
Source: HCFA/Office of the Actuary, 1996.

Medicare Hospital Payments Compared To Private Payers,1989-1994

As Hospital Costs Slow, Medicare Payments And Private Payments Converge



Source: Prospective Payment Assessment Commission, 1996

Medicare Physician Rates Compared To Private Payer Rates, 1989-1994

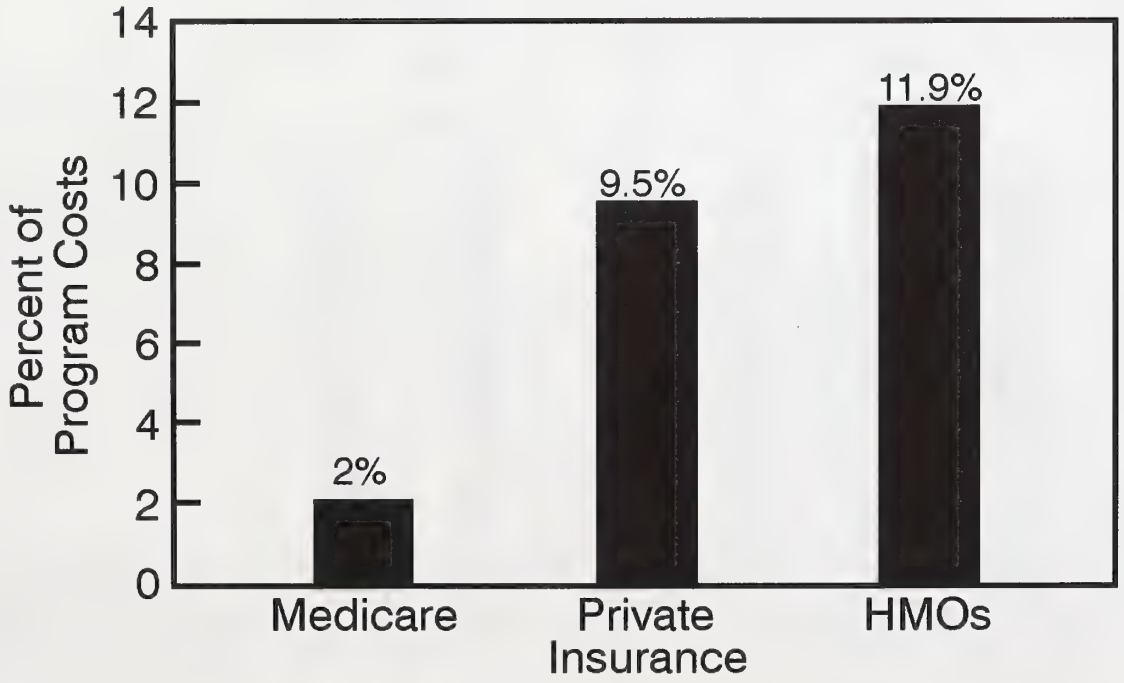
Medicare Payment Constraints Widened The Gap Between Medicare And Private Insurers In The Early 1990s. Higher Medicare Updates, Coupled With Lower Inflation In The Private Sector Have Begun To Narrow The Gap

Year	Ratio of Medicare to Private Fees
1989	0.71
1990	0.70
1991	0.65
1992	0.61
1993	0.62
1994	0.66

Source: Physician Payment Review Commission, 1996

Administrative Costs: Medicare Compared To Private Insurance

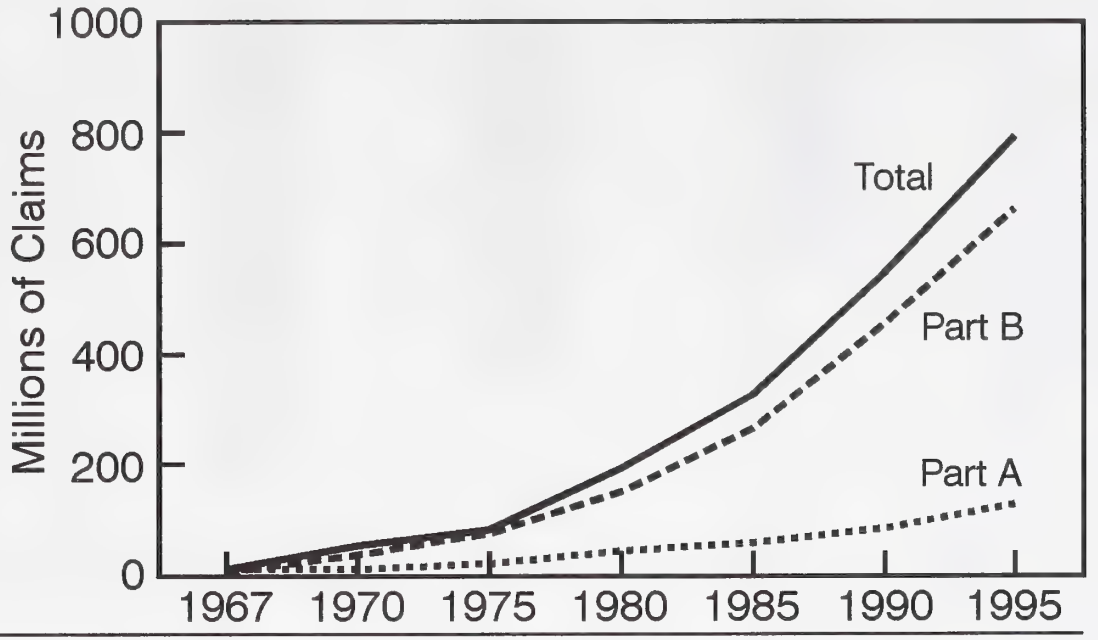
Medicare Administrative Costs Are Well Below Those Of Private Insurers And HMOs



Source: 1994 HCIA HMO data. Private health insurance from HCFA/Office of National Health Statistics, 1993

Medicare Claims Volume, 1967-1995

The Number Of Medicare Claims Processed Annually Has Grown From 19.1 Million In 1967 To Approximately 784.8 Million In 1995

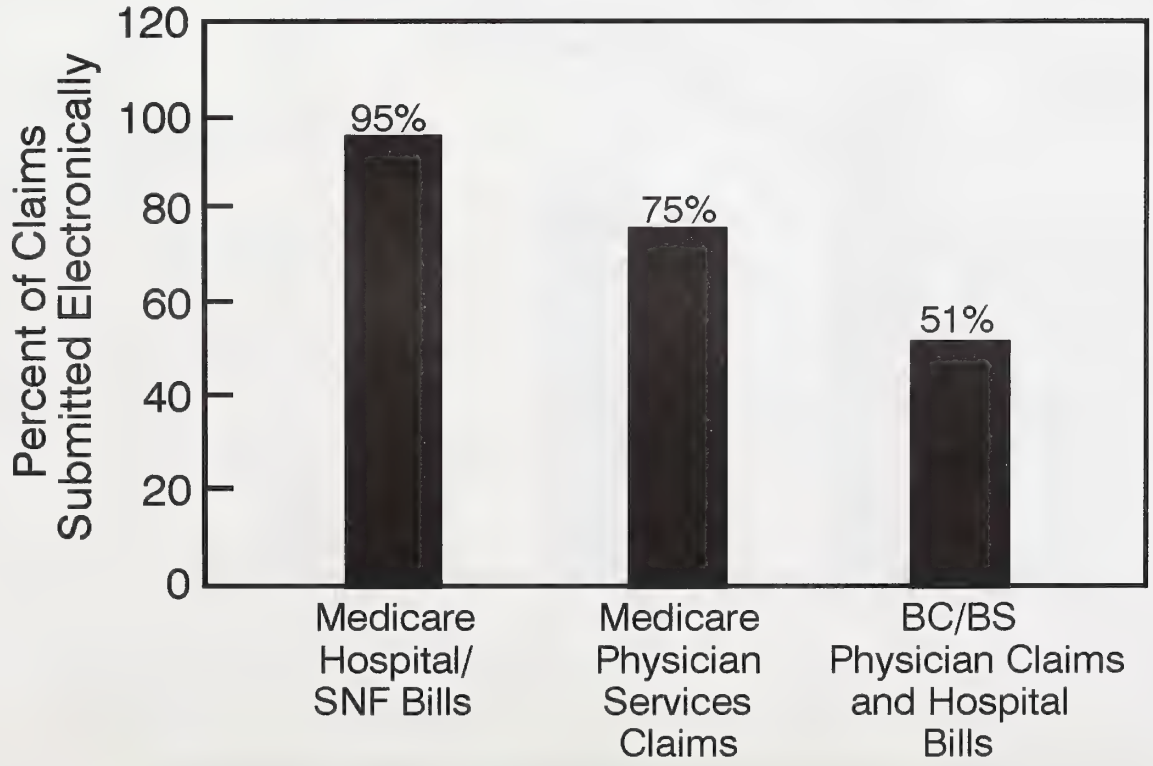


	1967	1970	1975	1980	1985	1990	1995
Part A ·····	10.0	17.1	26.6	41.8	58.5	83.2	129.2
Part B - - - -	18.1	43.8	81.6	155.0	267.2	453.9	655.6
Total (In Millions) ——	19.1	60.9	84.2	196.8	325.8	537.1	784.8

Note: 1995 figures are estimated.
Source: HCFA/Bureau of Program Operations, 1995.

Electronic Submission Of Claims, 1995

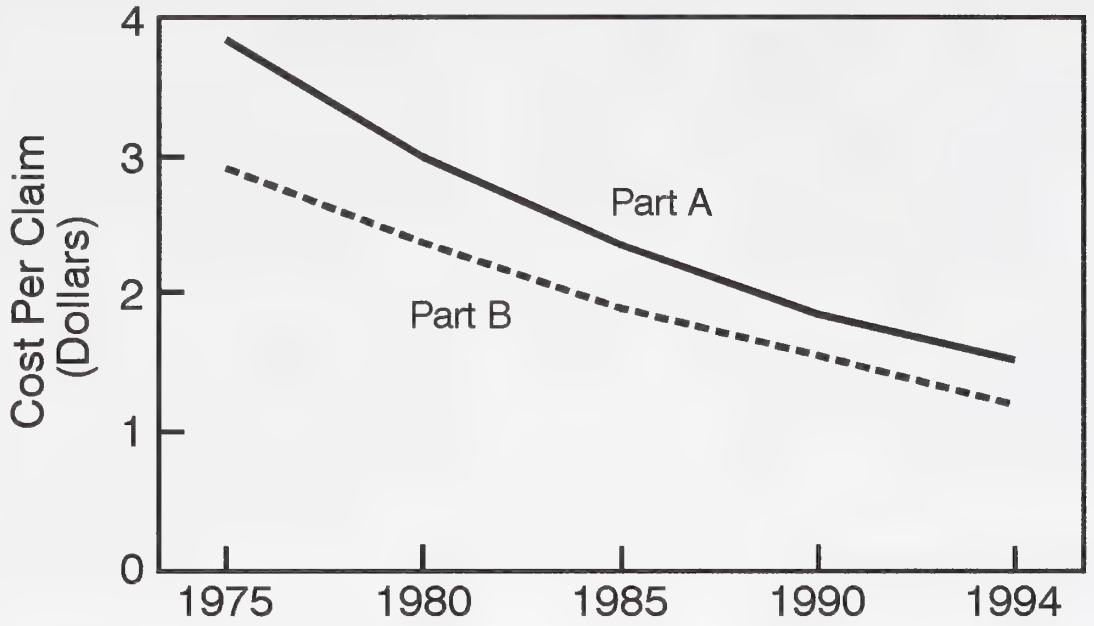
Over Three-Quarters Of Medicare Claims And Bills Are Submitted Electronically



Source: HCFA /Division of Budget; Blue Cross Association, 1996

Claims Processing, 1975-1994

On A Cost Per Claim Basis, Medicare Spent Approximately 60% Less In 1994 As In 1975



	1975	1980	1985	1990	1994
Part A ——	3.84	2.96	2.33	1.84	1.51
Part B - - - -	2.90	2.33	1.88	1.56	1.21

Note: Part A costs includes direct costs and overhead costs for bill payment, reconsiderations and hearing lines. Part B costs include direct costs and overhead costs for the claims payment, review and hearings, and beneficiary/physician inquires lines.
Source: HCFA/Bureau of Program Operations, 1995.

MEDICARE MANAGED CARE

The History Of Medicare Managed Care Options

Managed care options have been incorporated as a feature of Medicare since the inception of the program in 1965. The kinds of options offered have changed over the years, becoming more consistent with private sector options.

- The original Medicare legislation permitted certain prepaid organizations to receive payment on a cost reimbursement basis for their Medicare enrollees. In April of 1985, there were 109 such plans with 916,000 Medicare enrollees.

- A **risk-sharing** contract option for health maintenance organizations (HMOs) was introduced in 1972, one year before the enactment of the Federal HMO Act. Under the risk-sharing arrangement, HMOs had to submit cost reports to establish their costs in relation to Medicare fee-for-service expenditures in the geographic area. Savings were shared with the Medicare program, and losses were absorbed by the HMO. In 1985 there were only five HMOs with such contracts.

- In 1985 Medicare implemented legislative changes enacted in 1982, which introduced a managed care capitated payment option based on a purely prospective payment methodology (a Medicare **"risk"** option that involved no retrospective adjustments). The first contracts under the new legislative authority began in April of 1985.

- Beginning in 1996, Medicare risk HMOs will be able to offer their enrollees an **out-of-network** or **point-of-service** option permitting the use of non-network providers.

Enrollment In HMOs

Enrollment in risk plans has increased every year since the beginning of the risk program in 1985. Increases in enrollment have accelerated significantly in the last few years (Chart MC-1).

- Enrollment in HMOs has dramatically increased over the last few years, though Medicare enrollment levels lag behind non-Medicare levels. In 1996, nearly 9% of Medicare beneficiaries were enrolled in a risk HMO. An additional 2% of Medicare beneficiaries were enrolled in cost-reimbursed HMOs.

- Although Medicare HMO enrollment is less than half the level of the non-Medicare sector, where over one-third of the non-Medicare insured population is enrolled in HMOs,[1] the rate of growth in Medicare HMO enrollment has far exceeded non-Medicare growth rates over the past several years (Chart MC-2).

- From December 1994 through January 1996, Medicare risk HMO enrollment grew **41%**.

- Between December 1993 and December 1994, Medicare risk enrollment grew **25%**, while in the non-Medicare sector HMO enrollment grew 13.1% in that time period.

- In the space of three years, 1993 to 1995, enrollment in Medicare risk HMOs doubled.

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[1]Number derived by using Group Health Association of America figures for HMO enrollment by State (12/94), less Medicare HMO enrollment (August, 1994). Privately insured numbers computed using State populations as of July, 1994, less Medicare population, less uninsured for 1993 (from EBRI Data Book, 1995).

Number Of Risk-Contracting Plans

The early years of the risk program saw the quick entry and exit of a number of HMOs as Medicare contractors. In the past few years, more and more HMOs have entered the Medicare risk market. By 1997 a large majority of the nation's HMOs will have Medicare risk contracts.

- At the end of 1987 there were 161 Medicare risk contractors. Beginning in 1988, the number of risk HMO contracts began to decline. From 1988 to 1991 the number declined by 40% (Chart MC-3).
- Renewed HMO interest in Medicare contracting resulted in dramatic increases in the number of contractors in the mid-90s. The number of risk contracts doubled between 1990 and 1996.
- Fewer contractors are choosing to terminate Medicare risk contracts. Terminations reached a high of 38 plans in 1989, declining to zero in 1995 (Chart MC-4).
- A survey conducted by the American Association of Health Plans (the organization formed through the merger of the Group Health Association of American and the American Managed Care and Review Association) found that by the beginning of 1997, 70% of member organizations expected to have Medicare risk contracts[2]

Risk HMO Payments

Payments to managed care plans are becoming a larger percentage of Medicare program expenditures. Payment levels vary significantly by area, reflecting geographic variation in Medicare fee-for-service program expenditures.

- Payments to risk HMOs for the month of December 1995 totaled $1.3 billion, or about 9% of total monthly program outlays for Medicare.
- For 1996, county-standardized risk HMO monthly payments for aged beneficiaries range from $250 to $760.
- For January 1996, the average monthly per enrollee payment to Medicare risk HMOs was $440.

Medicare HMO Contractors And Enrollees

A large majority of Medicare beneficiaries--74%--have access to a managed care option. As of January 1996, 16 states had no Medicare risk HMOs, and 11 states had no risk or cost HMOs.

- Certain areas of the country have a greater proportion of Medicare beneficiaries enrolled in managed care. Medicare enrollment levels do not necessarily vary by the level of Medicare HMO payments in an area.
- Medicare beneficiaries in many areas of the country have the option of joining a managed care plan. In 1994, 74% of Medicare beneficiaries lived in areas served by a Medicare managed care plan, and 56% of beneficiaries had two or more plans available to them. Multiple plans are available in many metropolitan areas. The highest number is in Los Angeles County, where 15 Medicare risk HMOs were available in March 1995.

[2]Source: Statement of Jon Gabel, February 29, 1996.

- As of January 1996, 16 States had no Medicare risk plans, down from 1993 when 24 States had no risk plans.[3]

- Medicare risk HMO enrollment is highly concentrated in certain areas of the country and in certain plans. As of December 1995, the 15 largest Medicare risk HMOs had 50% of the enrollment. Seven of the 15 plans were in California. The five largest plans (all but one of which are in California) had 31% of total enrollment in December 1995. In 1986, 33% of Medicare risk HMO enrollment was in the largest five contractors.

- As of December 1995, California, Florida and Arizona had nearly 60% of total risk enrollment, even though only 19% of all Medicare beneficiaries live in these three States (Chart MC-5).

- Twenty ***counties*** accounted for 52% of the enrollment in risk HMOs in December, 1995. These 20 counties had 14% of the total Medicare population. The base AAPCC payment rates in the 20 counties averaged 125% of the United States per capita cost (the national average). The highest payment area among the 20 counties was Philadelphia, at 164% of the national average, and the lowest was Multnomah County (Portland, OR), at 98% of the national average.

- HMO penetration (the extent to which individuals enroll in managed care plans) varies across States, for both Medicare and non-Medicare enrollment (Charts MC-6a, 6b). The level of Medicare HMO penetration does not necessarily vary by the level of Medicare HMO payments (Chart MC-7).

Benefits Available To Medicare HMO Enrollees

Most Medicare HMO enrollees have low out-of-pocket costs and are provided with a substantial level of additional services not covered by Medicare--such as preventive care and prescription drugs. Many HMOs charge no premium, and in almost all cases, HMO premiums are significantly lower than Medigap premiums.

- The majority of Medicare risk HMOs use savings to finance reduced premiums and/or additional benefits for their members. In 1996, 20% of projected Medicare payments will be returned to beneficiaries in the form of reduced premiums and/or additional benefits.[4] Expressed in dollars, $4 billion of $20 billion in projected annual Medicare payments to risk HMOs will be used for enhanced benefits.

- The majority of risk HMOs offer zero-premium[5] plans (Chart MC-8), and enrollees often receive free additional benefits, including drug coverage (Chart MC-9). In 1995, nearly half of all risk plans included prescription drugs as part of the basic benefit package, including 63 plans that offered drugs in a basic package with no premium (Chart MC-10).

- Though available only in certain areas of the country in the early years of the risk program, plans that charge no premium are increasingly available in many areas. In

[3] Only three States had no commercial HMOs at the end of 1994 and four states had only one HMO. Source: Group Health Association of America Patterns in HMO Enrollment, June 1995.

[4] Source: HCFA Office of Managed Care analysis of premium rate submissions to HCFA.

[5] Enrollees continue to be responsible for payment of the Medicare Part B premium.

1987, zero-premium plans were available only in four metropolitan areas. In 1991, 10 areas had zero-premium plans. By 1995, 38 metropolitan areas had zero-premium HMOs.

- A large majority of risk HMO enrollees are in plans with premiums well below the levels of premiums for Medicare supplemental (Medigap) insurance. The national average risk HMO premium for a basic package (which may include additional benefits) was $21.00 per month in 1995 (Charts MC-11a, 11b[6]).

- **Out-of-Network Option.** As of January 1996, 49 risk HMOs were authorized to include an out-of-network option for Medicare beneficiaries, permitting enrollees to be reimbursed for services obtained through providers not associated with the HMO (generally referred to as point-of-service in commercial HMO and insurance offerings). Plans in 20 States have approval for a 1996 out-of-network option, including 12 plans in California.

Beneficiaries Who Enroll In HMOs

HMO enrollees are less likely to be entitled to Medicare on the basis of disability, 85 years or older, on Medicaid or institutionalized.

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[6]Medigap premiums and HMO premiums are not entirely comparable for many reasons. The comparison charts use Prudential-AARP's plan C as most similar to a basic HMO package of benefits, and most similar in rating and underwriting practices. Most Medigap insurers other than Prudential-AARP (which has 20% of the market (National Association of Insurance Commissioners: Medicare Supplement Loss Ratios in 1994)) do not "community rate" their premiums. Under a community rating system, all individuals within the same policy are charged the same rate regardless of the age at which they bought the policy, how long they have held the policy, or how old or sick they are. Other Medigap premiums are set according to one of two other rating methodologies: "age at issue" (determined depending on the age the person was when he or she bought the policy) or "attained age" (determined for specific age ranges regardless of when the person first bought the plan). Community rating is equivalent to the requirement imposed on Medicare HMOs that they have an invariable premium for all Medicare enrollees.

Medigap insurers other than Prudential-AARP (and a few other insurers) also underwrite. Underwriting means 1) the insurer can refuse to issue a policy based on a person's health status if the person is enrolling outside of the Medigap enrollment period (which occurs during the first 6 months of enrollment in Medicare Part B as an aged individual), or 2) if the insurer does issue a policy, it can charge the individual a higher premium based on an estimate of the higher degree of risk the individual presents. Most Medigap insurers impose a waiting period for the coverage of pre-existing conditions when an individual first purchases a Medigap policy, even when the policy is purchased during the Medigap enrollment period. Medicare-contracting HMOs cannot underwrite and cannot impose pre-existing condition waiting periods.

In the accompanying charts, comparison is made between average HMO premiums (not weighted by enrollment, and without consideration of the benefits included for the premium) and Prudential-AARP premiums for the standardized Medigap plan C. Prudential-AARP uses community rating for package C in all States except Florida, where the State requires all Medigap plans on an age-at-issue basis. Prudential-AARP also has premiums that vary by regions within certain States. In the charts, the HMO average premiums are an average of all premiums in a State, including multiple premiums of a single HMO. Medicare risk HMOs are permitted to vary their premiums by county. For example, in New Jersey, there was only one Medicare risk contractor in 1995, but the HMO was authorized to charge three different levels of premium in different parts of its service area. The charts also include the highest and lowest basic premium charged by risk HMOs in each State. (Note also that the charts do not take into account HMOs operating across State lines. For example, the HMO premium for Virginia is based on the premium of the sole Virginia-based risk HMO operating in the State. Northern Virginia has zero premium plans offered by HMOs based in Maryland and the District of Columbia.) .

- In the month of December 1995, 1.06%[7] of risk HMO enrollees were institutionalized (residing in a nursing home or similar institutional arrangement), while Medicare Current Beneficiary Survey data indicate that nearly 6% of the general Medicare population is institutionalized (Chart MC-13).

- According to a recent study, "Beneficiaries who are dually eligible [have both Medicare and Medicaid coverage] are two-thirds less likely to enroll in HMOs than are other Medicare beneficiaries--less likely to enroll even than the under-65 group (disabled)."[8] A number of barriers exist that prevent greater enrollment of dual-eligibles in Medicare risk HMOs. [9]

- Similar barriers to enrollment exist for the institutionalized: many are eligible for Medicaid, are over age 85 or are less likely to change providers in order to enroll in a managed care plan.[10]

- The very poor are less likely to be enrolled in HMOs (reflecting their status as dual eligibles), and the very wealthy are also less likely to be HMO enrollees (Chart MC-14).

- HMO enrollees tend to report better health than non-HMO enrollees[11] (Chart MC-15). This may reflect a variety of factors, including the types of Medicare beneficiaries who are likely to enroll in HMOs, and improved access to care among HMO enrollees.

Beneficiary Attitudes Towards HMOs

Beneficiaries are happy with their out-of-pocket costs as risk HMO enrollees. Beneficiaries in risk HMOs express greater satisfaction with the ease of getting care and the kind of information they receive about their medical condition (Chart MC-16).

- HMO enrollees were significantly more satisfied with out-of-pocket costs for medical care, as compared to beneficiaries in fee-for-service Medicare.[12]

- Each category of beneficiaries had similar attitudes in terms of availability of care and the ease of getting care.

- Impressions of the quality of care varied from one group to the other: 37% of risk HMO enrollees were "very satisfied" with their care while only 30% of fee-for-service beneficiaries said they were "very satisfied." Those "satisfied" with their care included 55% in fee-for-service and 52% in HMOs. Fewer than 1% of beneficiaries in

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[7]Source: SAS data development of weighted average based on HMO reporting of institutionalized enrollees. HMOs report the number of institutionalized enrollees on a monthly basis. Medicare payments for such individuals are higher than for non-institutionalized enrollees for individuals who have been enrolled for 30 days or more.

[8]W. Pete Welch, "Growth in HMO Share of the Medicare Market, 1989-94," unpublished paper, The Urban Institute, January 1996.

[9]See P. Saucier, "Federal Barriers to Managed Care for Dually Eligible Persons," Portland, Maine: National Academy for State Health Policy (August, 1995).

[10]Medicare payments to risk HMOs are adjusted at the individual beneficiary level, with adjustments for various demographic factors, including institutional and Medicaid status, as noted above. If an HMO has a smaller share of institutionalized members as compared to the local Medicare population, the HMO's overall payments will be less than if the HMO's share of institutionalized members mirrored their number in the community because Medicare's payments for institutionalized individuals are higher, generally, than for the non-institutionalized.

[11]HCFA/Office of the Actuary; Medicare Current Beneficiary Survey, 1993

[12]HCFA/Office of the Actuary; Medicare Current Beneficiary Survey, 1993

either category were "very unsatisfied" with their care, but 5.5% of HMO enrollees were "unsatisfied" with their care versus 2.9% of fee-for-service beneficiaries.

Types Of Contracting Organizations And Enrollment Distribution

In the early years of the Medicare HMO program, the largest HMOs in the country generally did not have Medicare risk contracts. In the past few years, Medicare HMO risk contracting has become an important market segment for many of the country's top HMOs.

Though the largest Medicare risk plans have the majority of enrollment, enrollment is becoming less concentrated. New plans have a large segment of the enrollment.

- In 1986, none of the five largest Medicare risk plans at the time was among the five largest HMOs in the nation, and only one was among the largest 15. As of 1994, three of the five largest HMOs were also among the five largest Medicare risk contractors.

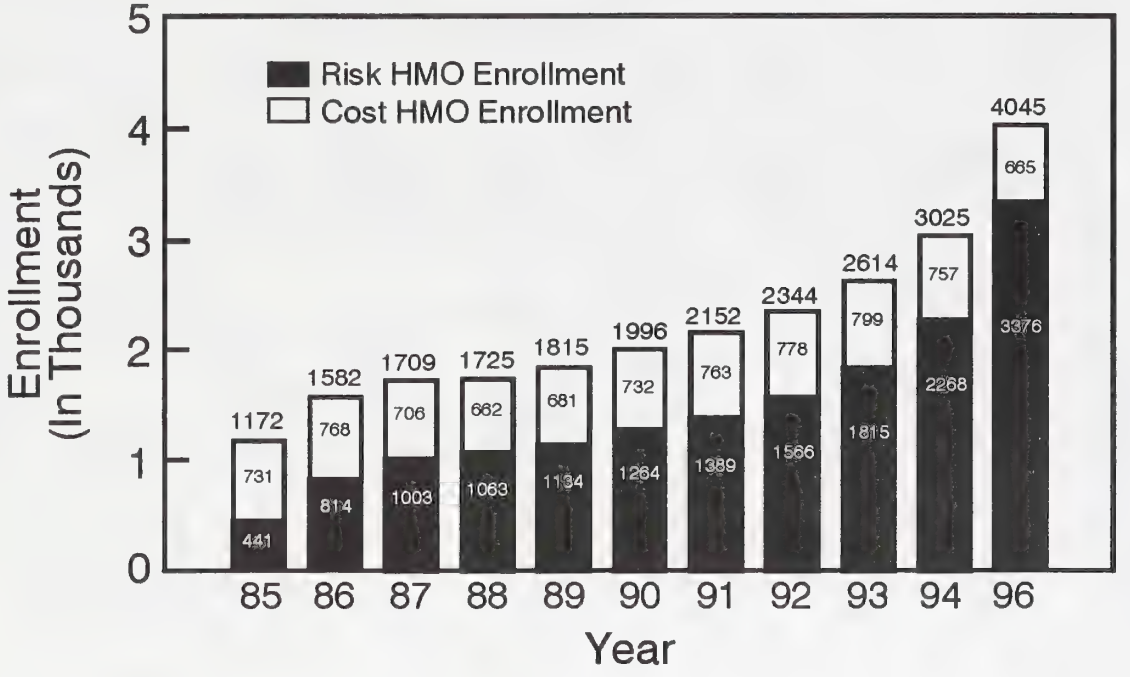
- Concentration in the largest plans is declining (Chart MC-17). If this trend continues, it will be the reverse of the trend in the HMO industry as a whole. In 1994, 72% of total national HMO enrollment was in plans with 100,000 or more members, while in 1988 55% of enrollment was in plans with 100,000 or more members.13 (In December 1995, the five largest Medicare risk HMOs were also the only plans with enrollment of 100,000 or more.)

- As of December 1995, 26% of all Medicare risk enrollment was in plans that have had Medicare risk contracts for three years or less, with 14% of enrollment in plans that are two years old or less (Chart MC-18).

[13]Source: Group Health Association of America Patterns of Enrollment, June 1995.

Medicare HMO Enrollment, 1985-1996

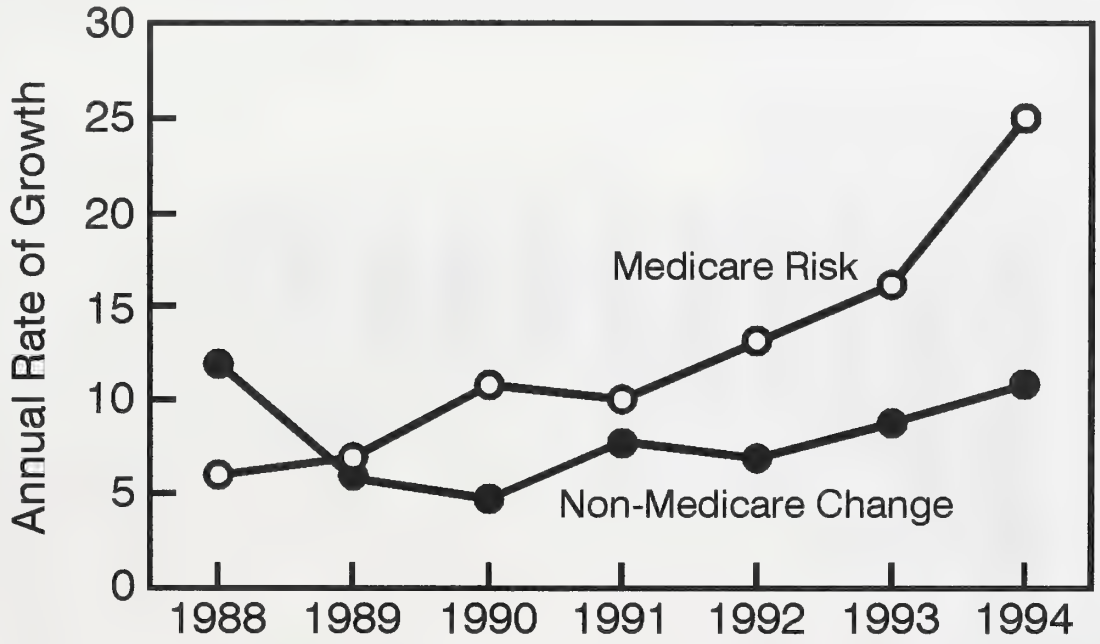
Enrollment Has Increased Every Year Since The Beginning Of The Program



Note: Cost HMO Enrollment Numbers Include Cost HMOs and Health Cost Prepayment Plans.
*All data as of December of the year indicated, except for 1996, which is as of March.
Source: HCFA/Office of Managed Care

Relative Growth in HMO Enrollment

Medicare Risk Enrollment in Recent Years has Increased at an Accelerated Rate



	1988	1989	1990	1991	1992	1993	1994
Non-Medicare Change	12%	6%	5%	8%	7%	9%	11%
Medicare Risk	6%	7%	11%	10%	13%	16%	25%

Note: All data as of December of the year indicated.
Source: HCFA/Office of Managed Care; Group Health Association of America Patterns of Enrollment, 1995 Edition.

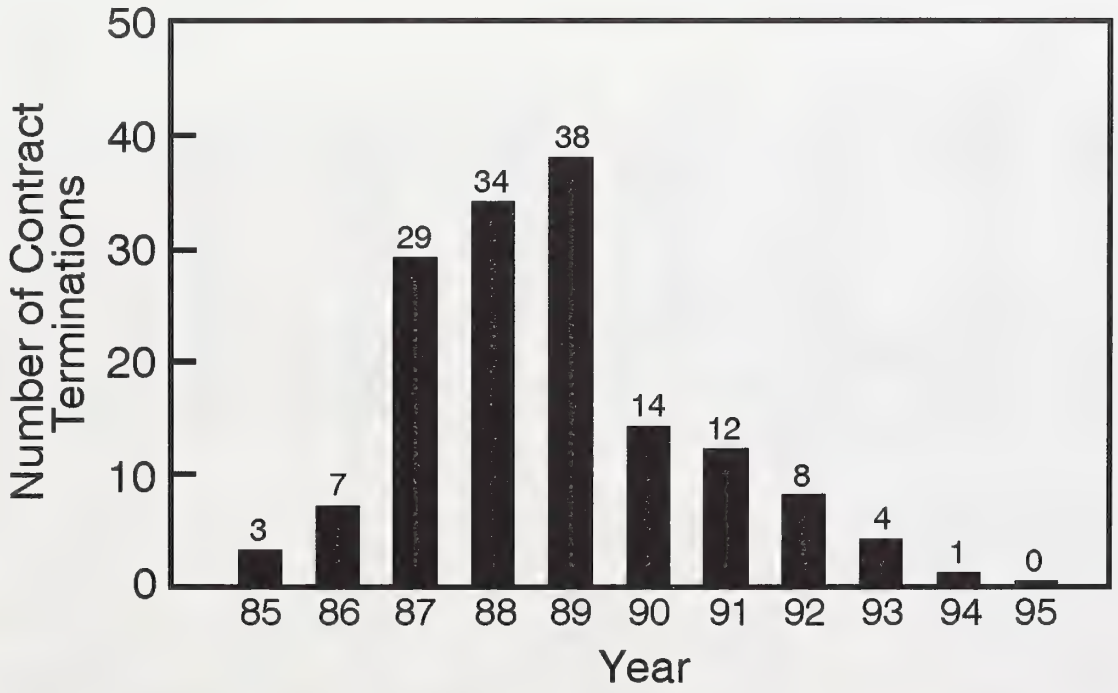
Medicare HMO Contracts, 1985-1996

Risk Contracts Are At Their Highest Historic Levels

*Note: all data as of December of the year indicated, except for 1996, which is as of January.
Source: HCFA/Office of Managed Care

Medicare Risk Contract Terminations, 1985-1995

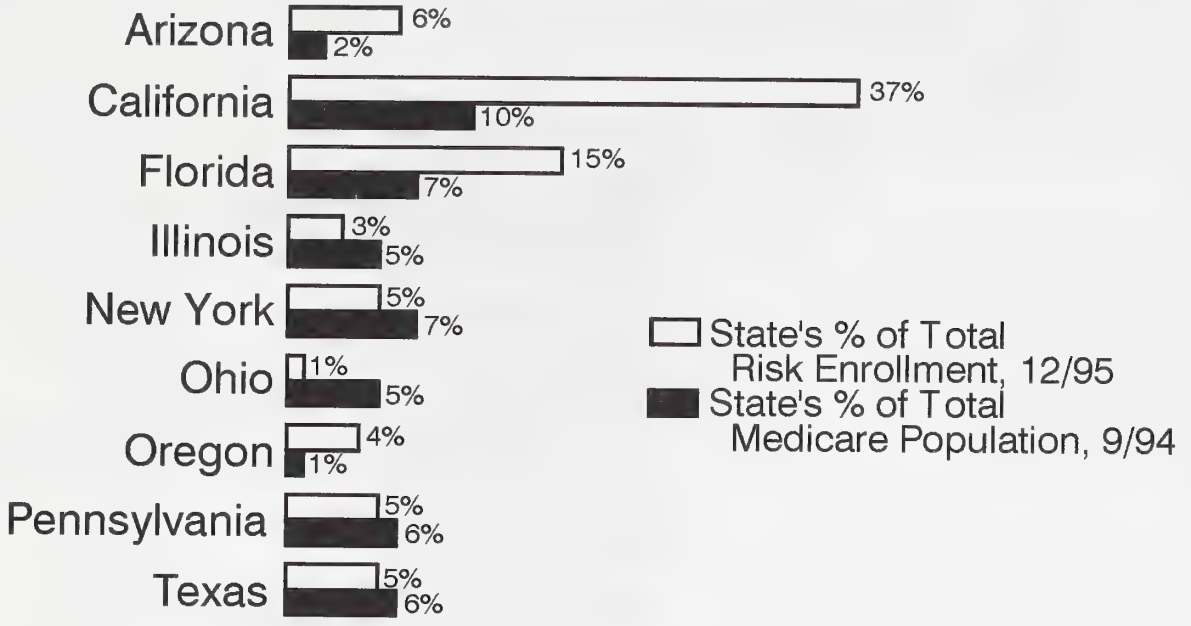
Terminations Are Becoming Rare



Source: HCFA Special Analysis Staff Development of Office of Managed Care Data, 1996

Distribution Of Medicare Risk Enrollees Among Selected States, 1994-1995

California, Florida And Arizona Account For Over Half Of All Risk Enrollment But Only 19% Of Total Medicare Beneficiaries

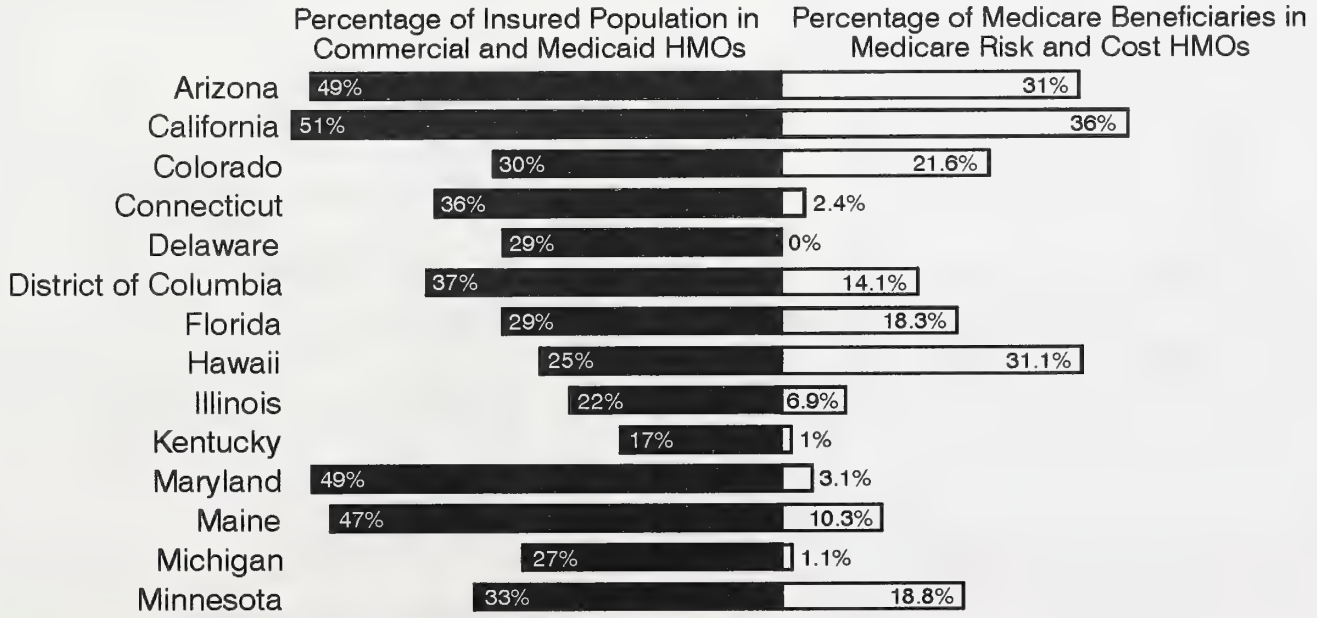


	AZ	CA	FL	IL	NY	OH	OR	PA	TX
Risk Enrollment (Thousands)	182	1153	470	83	159	33	116	164	152

Source: HCFA/Special Analysis Staff Development of Office of Managed Care Data, 1996

Medicare And Non-Medicare HMO Penetration In Selected States, 1993-1995

Non-Medicare Penetration Exceeds Medicare HMO Penetration In Almost All States

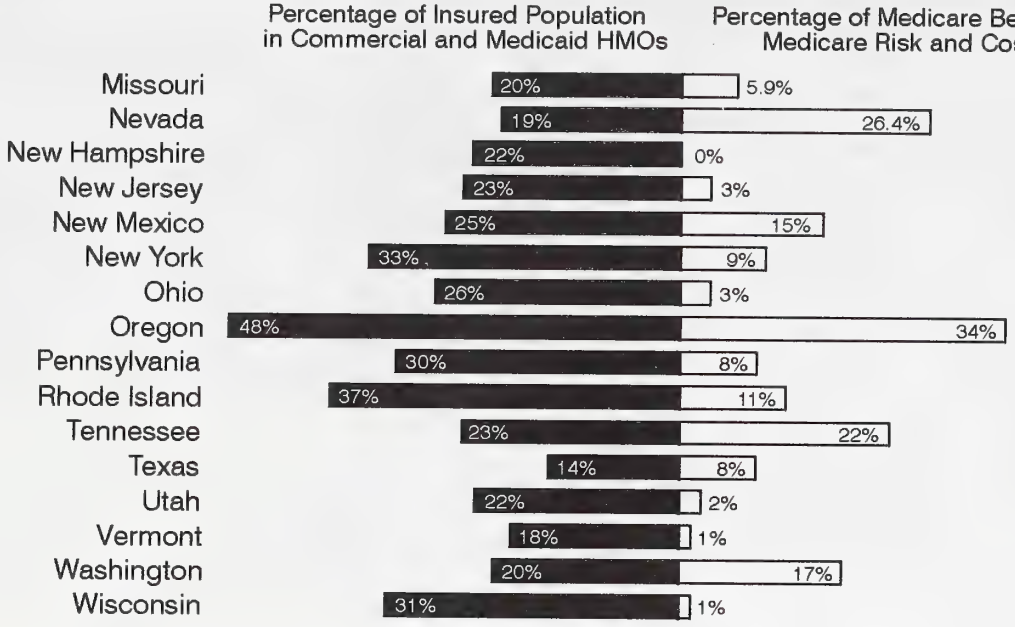


	AZ	CA	CO	CT	DE	DC	FL	HI	KY	MD	MA	MI	MN
Medicare Risk (%)	31	32	17	0	0	5	18	9	1	2	8	1	9
Medicare Cost (%)	0	4	4.6	2.4	0	9.1	0.3	22.1	0	1.1	2.3	0.1	9.8

Source: HCFA Special Analysis Staff and Office of Managed Care Data & Medicaid Bureau Data; EBRI (see note in text for methodology). Medicare HMO penetration percents are as of December, 1995.

Medicare And Non-Medicare HMO Penetration In Selected States, 1993-1995

Non-Medicare Penetration Exceeds Medicare HMO Penetration In Almost All States



	MO	NV	NH	NJ	NM	NY	OH	OR	PA	RI	TN	TX	UT	VT	WA	WI
Medicare Risk (%)	4	25	0	2	15	6	2	24	8	9	0	7	0	0	14	0
Medicare Cost (%)	1.9	1.4	0	1	0	3	1	10	0	2	22	1	2	1	3	1

Source: HCFA Special Analysis Staff and Office of Managed Care Data & Medicaid Bureau Data; EBRI (see note in text for methodology). Medicare HMO penetration percentages are as of December, 1995.

Medicare Risk HMO Penetration In High And Low Payment Areas, December 1995

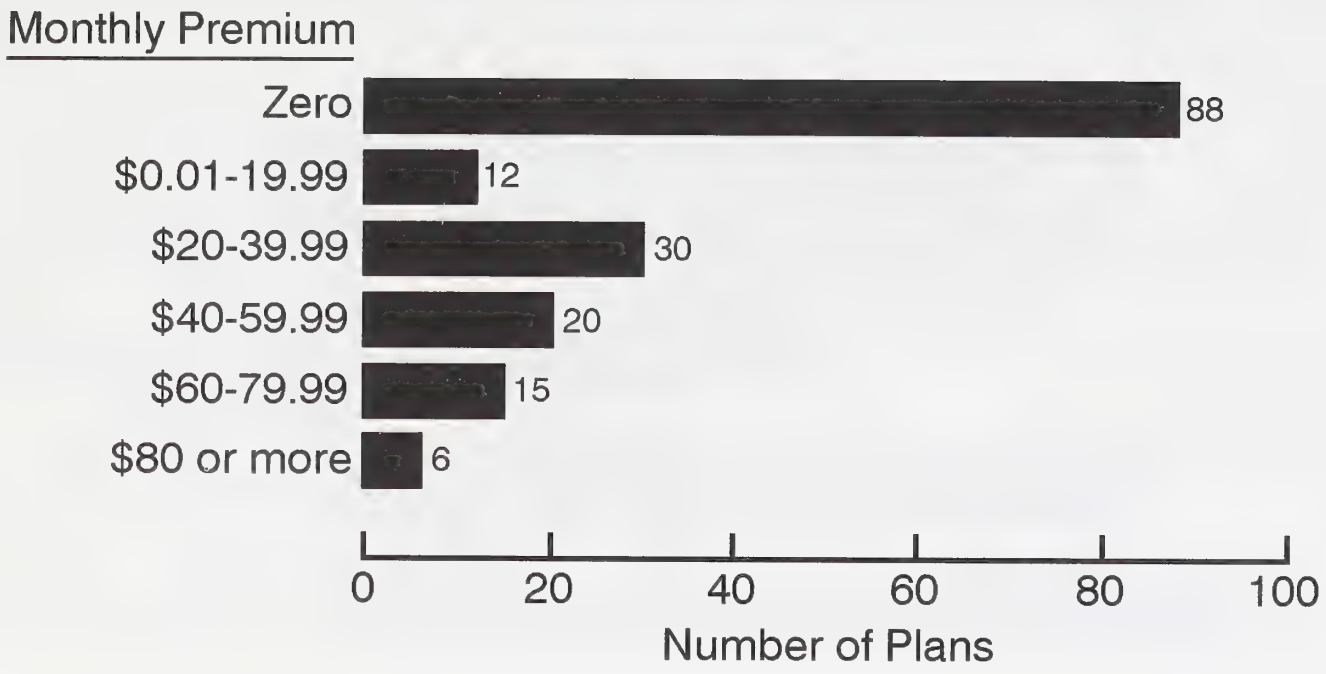
Not All High Payment Areas Have High HMO Enrollment; Many Low Payment Areas Have High Enrollment

County	Number of Risk Plans Available	12/95 Medicare Risk HMO Penetrations	1994 % of Commercially Insured in HMO for MSA	Aged AAPPCC 1996	% 1996 USPCC
High Payment Areas					
Dade (Miami)	8	33%	45%	$687	162%
Los Angeles	15	34%	64%	$587	133%
Richmond, NY	3	18%	45%	$759	172%
New York	3	5%	45%	$715	162%
Queens, NY	5	10%	45%	$652	147%
Wayne, MI (Detroit)	1	1%	35%	$628	142%
Baltimore City	4	2%	44%	$614	139%
Low Payment Areas					
Clackamas (Portland, OR)	5	44%	54%	$368	83%
Multnomah, OR	5	44%	54%	$385	87%
Washington, OR	5	44%	54%	$395	90%
Hennnepin (Minneapolis)	3	20%	59%	$387	82%
Ramsey (St. Paul)	3	23%	59%	$411	93%

Source: HCFA/Office of the Actuary; Office of Managed Care; for commercial numbers, Group Health Association of America Patterns of Enrollment, June 1995

Risk HMO Monthly Premium Levels, 1995

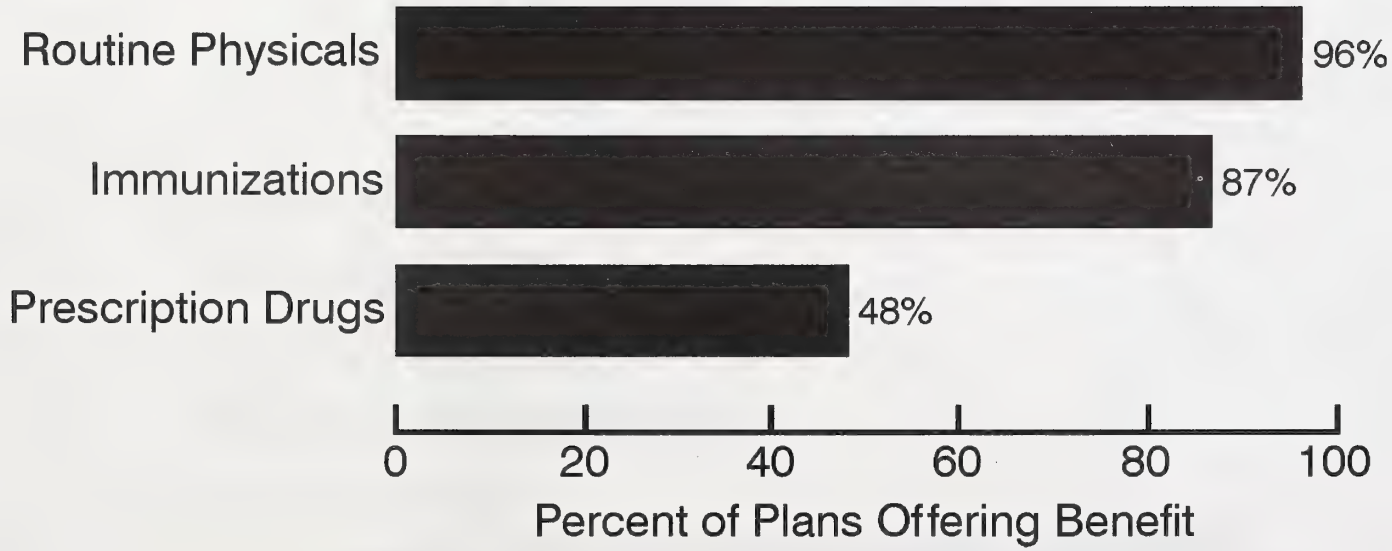
51% Of Plans Have No Basic Premium



Source: HCFA/Office of Managed Care Monthly Report, December 1995

Risk HMO Additional Benefits, 1995

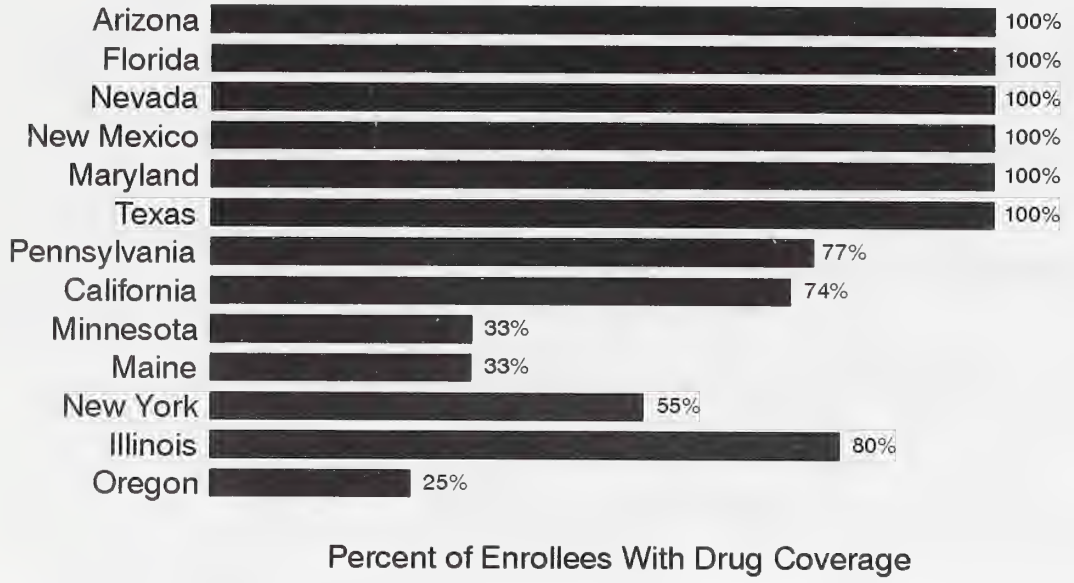
48% Of Plans Offer Prescription Drug Benefits



Source: HCFA/Office of Managed Care Monthly Report, December 1995

Percent Of Risk Plans With Drug Coverage In Basic Plan For Selected States, 1996*

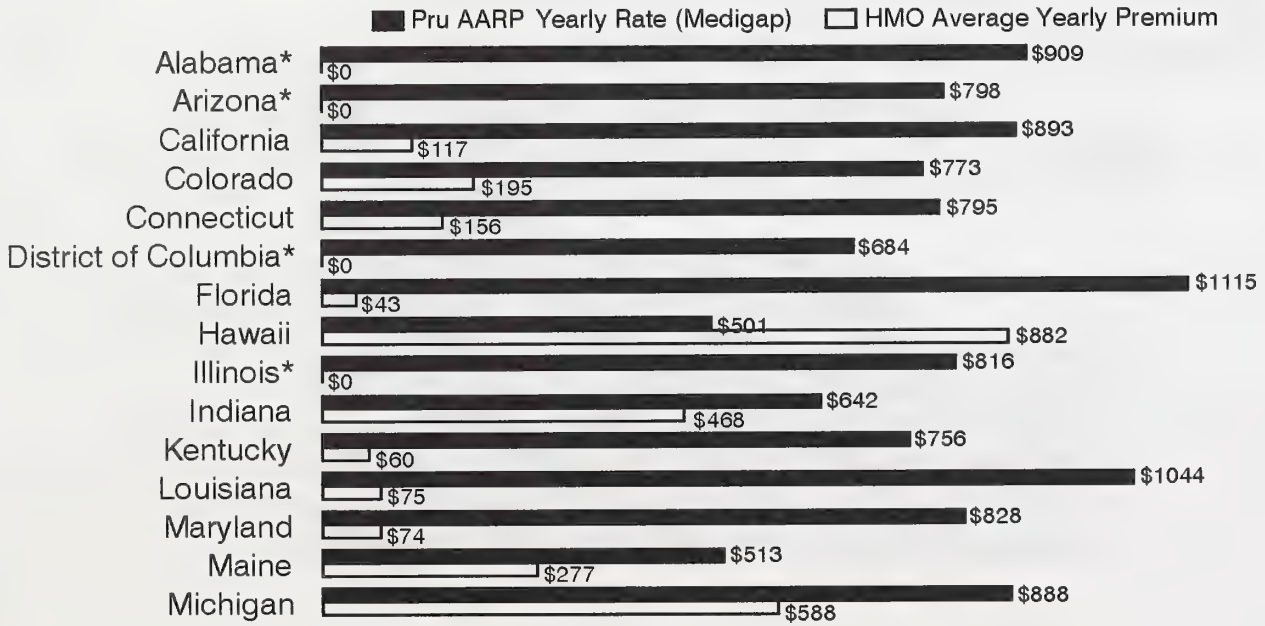
In Some States All HMOs Include Drug Coverage (see note)



Note: For MD, NV, NM, PA, MN, MA, IL and OR, not all beneficiaries in each plan have drug coverage-residents of some counties do not have drugs included in basic coverage even though the HMO in which they are enrolled includes drugs in some of the counties the HMO serves.
*As of January 1996.
Source: HCFA Special Analysis Staff and Office of Managed Care (OMC) Development of OMC Data.

Prudential AARP Medigap Premiums Compared To Risk HMO Premiums, 1995

HMO Premiums Are Generally Much Lower Than Medigap Premiums

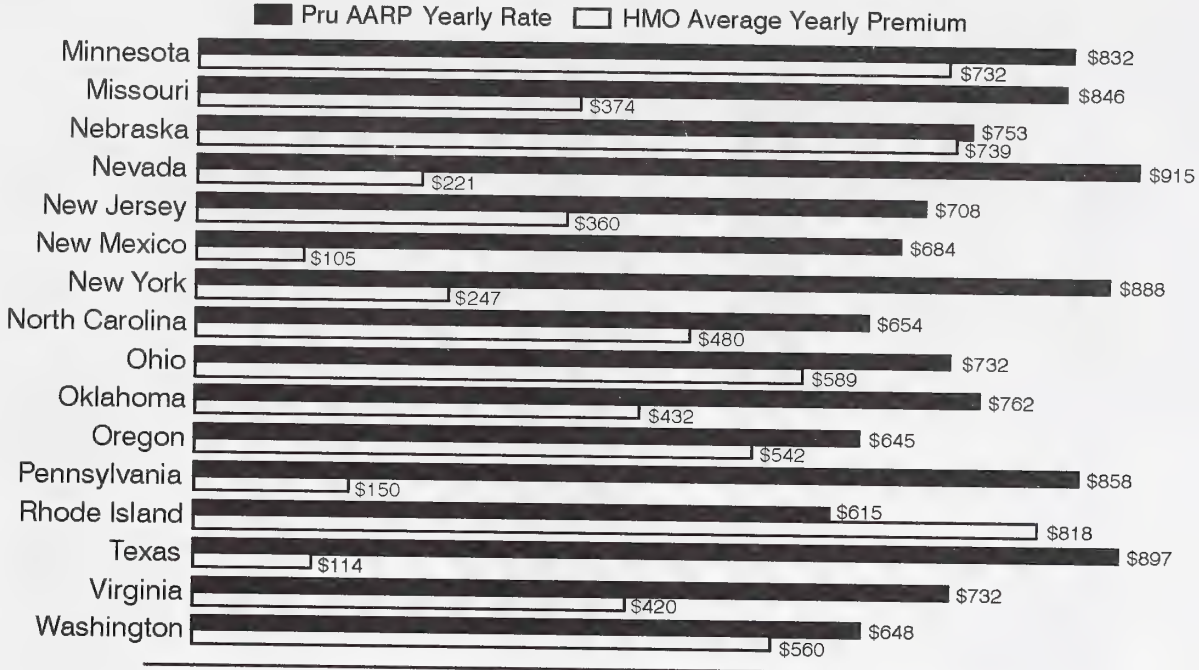


	AL*	AZ*	CA	CO	CT	DC*	FL	HI	IL*	IN	KY	LA	MD	MA	MI
HMO Highest Basic	0	0	720	756	468	0	480	882	0	708	120	300	588	1332	768
HMO Lowest Basic	0	0	0	0	0	0	0	882	0	228	0	0	0	0	408

Source: HCFA Special Analysis Staff Development of Office of Managed Care Data; AARP
*Indicates all HMO basic premiums in state is $0.

Prudential AARP Medigap Premiums Compared To Risk HMO Premiums, 1995

HMO Premiums Are Generally Much Lower Than Medigap Premiums

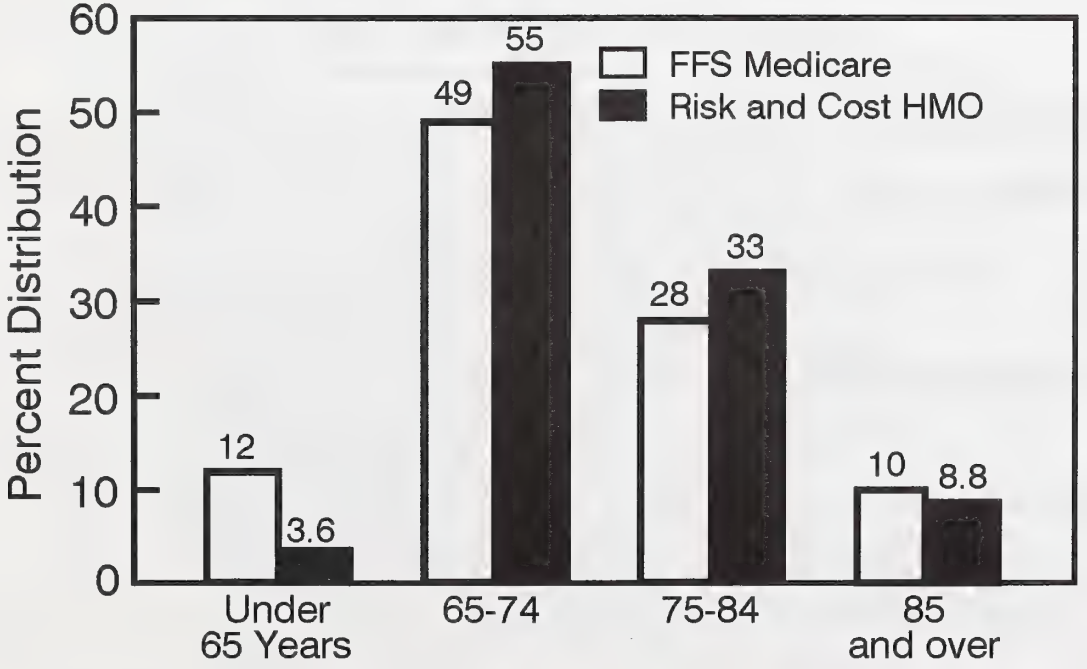


	MN	MO	NE	NV	NJ	NM	NY	NC	OH	OK	OR	PA	RI	TX	VA	WA
HMO Highest Basic ($)	840	1284	0	0	360	420	1092	480	1056	432	972	408	912	720	420	1044
HMO Lowest Basic ($)	0	0	0	0	0	0	0	480	0	432	0	0	0	0	0	0

Source: HCFA Special Analysis Staff Development of Office of Managed Care Data; AARP.
*Indicates all HMO basic premiums in state is $0.

Age Distribution of HMO Enrollees, 1995

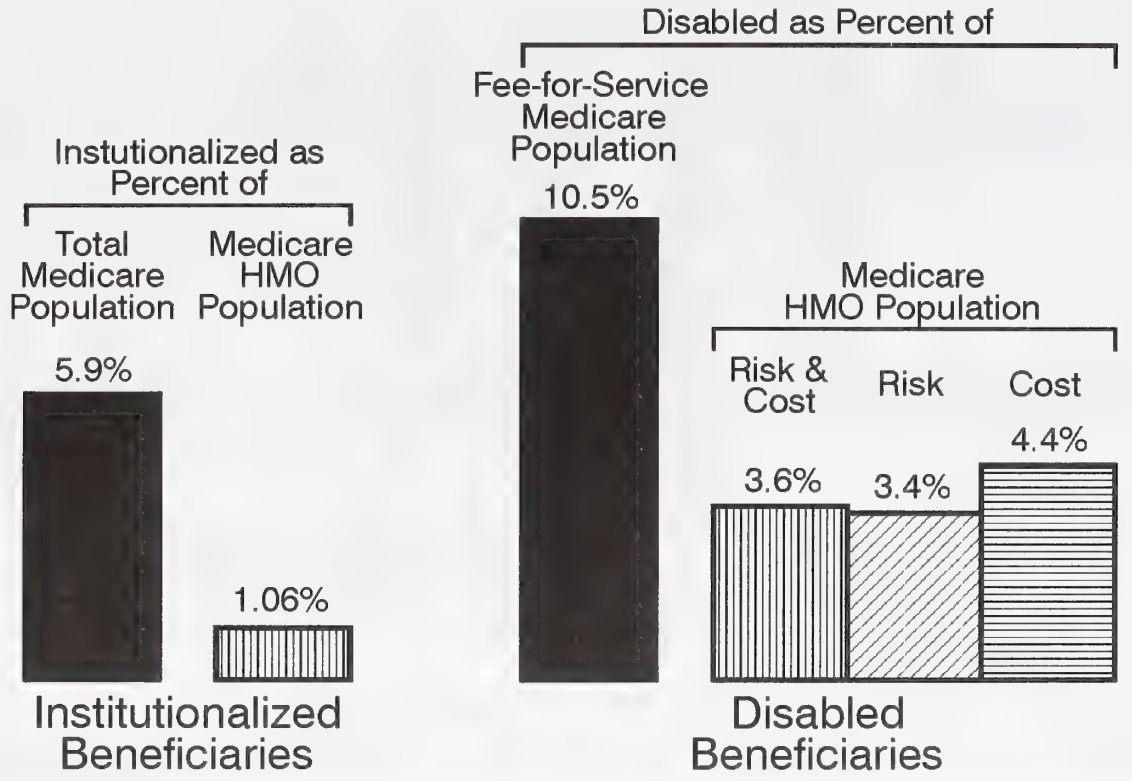
The Very Old And Individuals Entitled To Medicare On The Basis Of Disability Are Less Likely To Be HMO Enrollees



Source: HCFA/Office of Managed Care & Office of Research and Demonstrations

Characteristics Of Medicare Risk HMO Enrollees, 1995

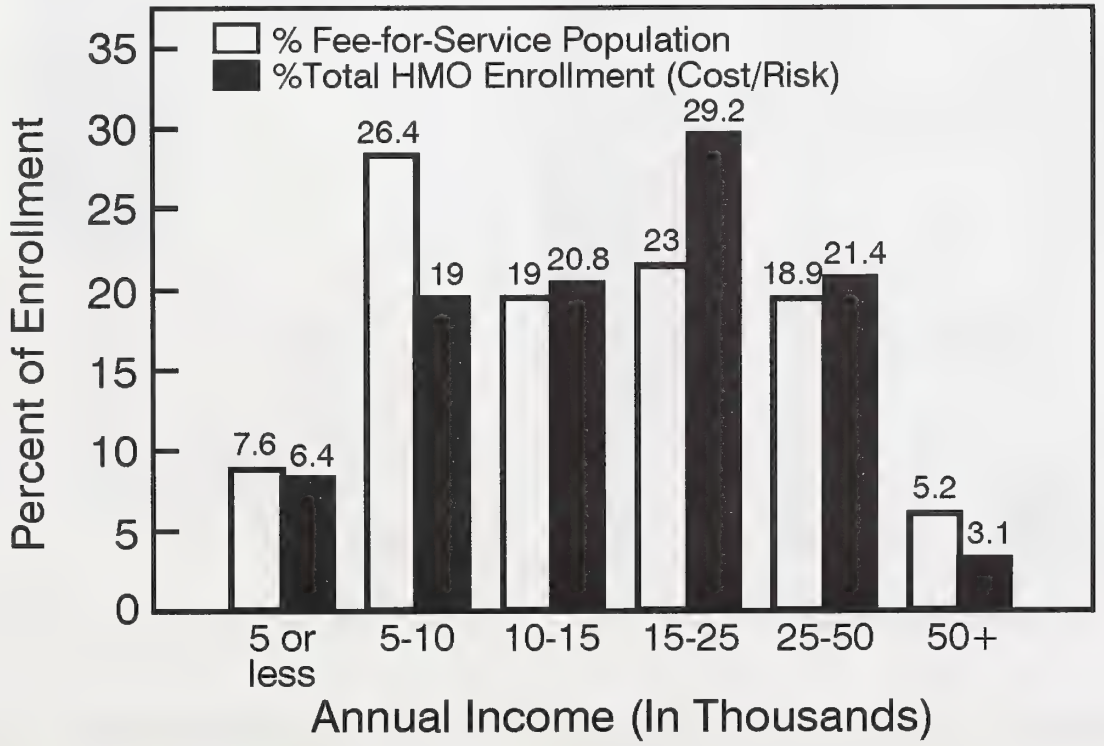
The Institutionalized And Beneficiaries Entitled To Medicare On The Basis Of Disability Are Less Likely To Be Risk Enrollees



Source: HCFA/Office of Managed Care; Special Analysis Staff Development of Office of Managed Care Data; and Office of the Actuary; data from the Medicare Current Beneficiary Survey, 1993

Distribution By Income Of HMO Enrollees Verses Non-HMO Enrollees, 1993

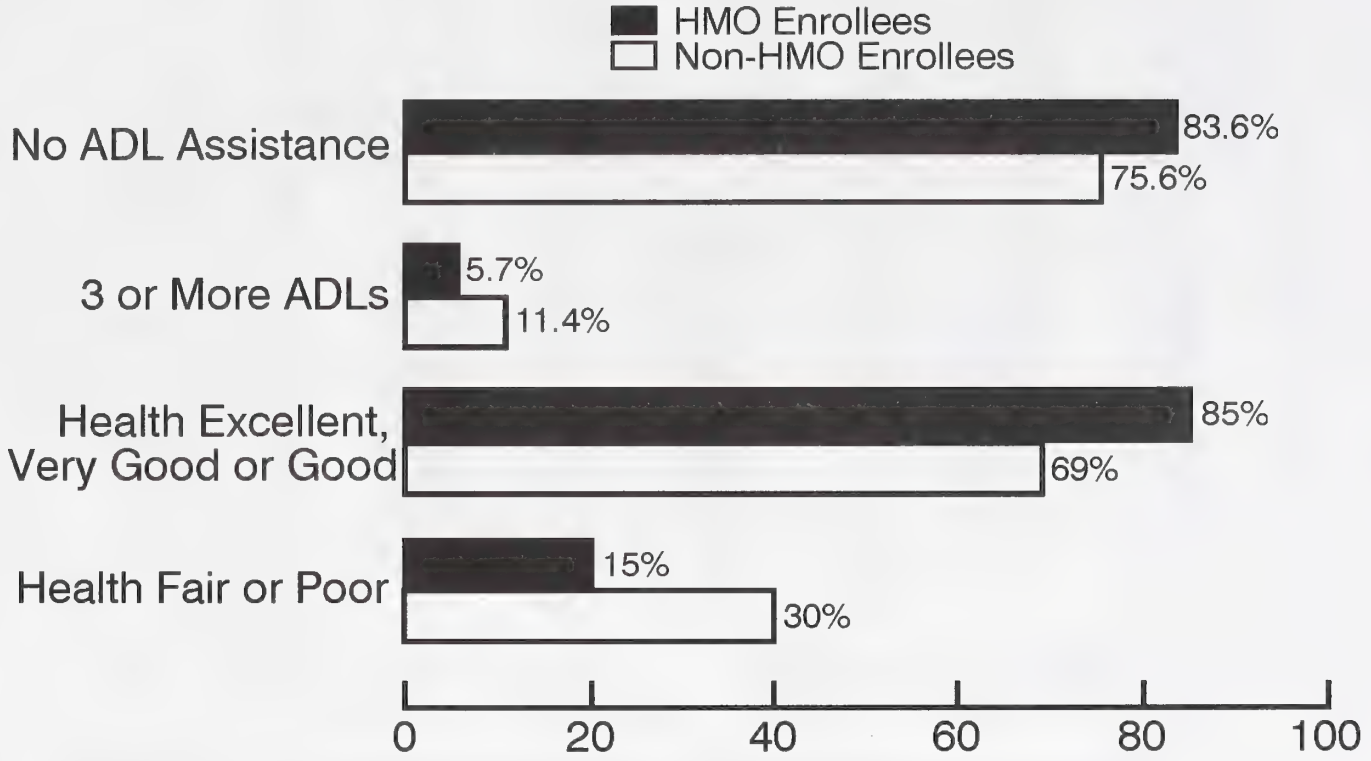
Within Income Groups, The Least Wealthy And the Very Wealthy Are Less Likely To Be HMO Enrollees



Source: HCFA/Office of the Actuary, data from the Medicare Current Beneficiary Survey, 1993 does not include beneficiaries not reporting or partial reporting of income.

Relative Health Status Of HMO Enrollees, 1993

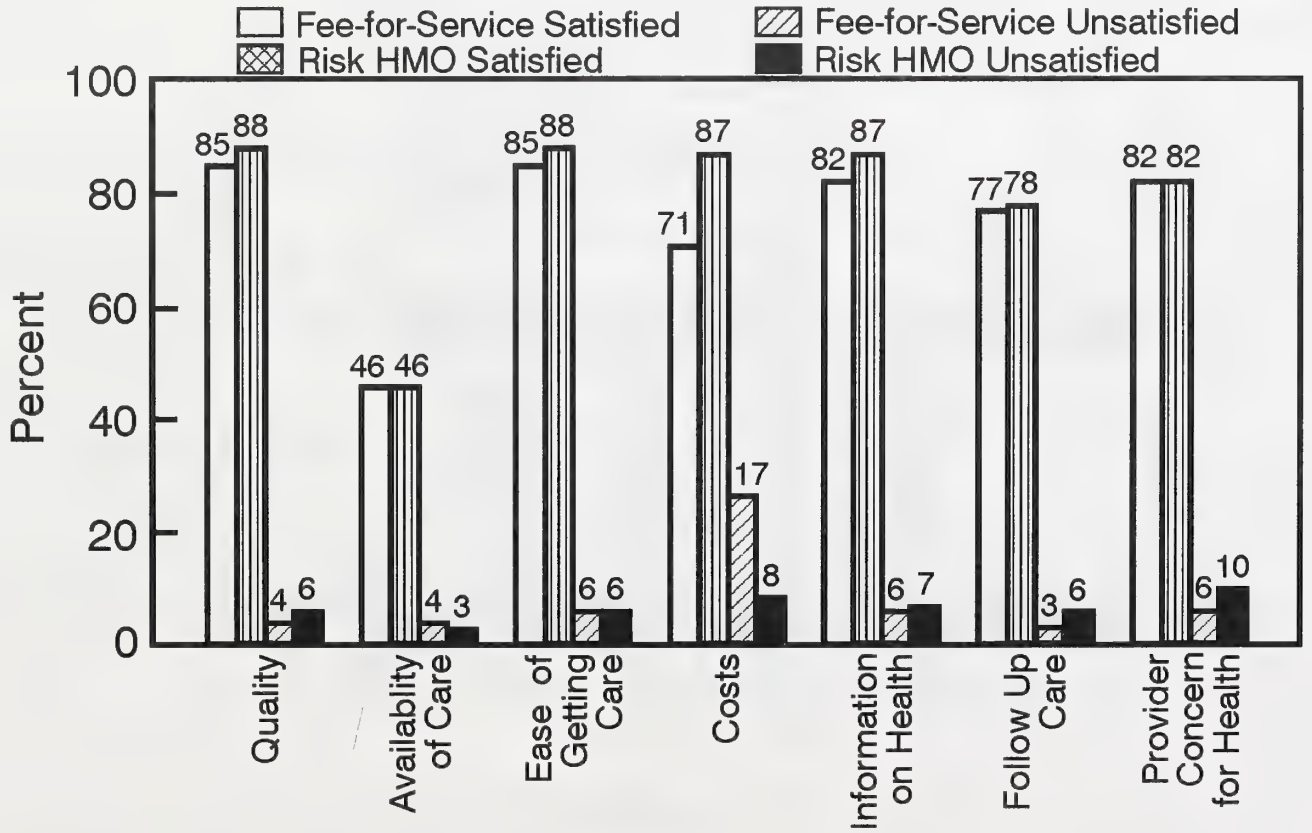
In 1993 Risk HMO Enrollees Were Healthier Than Non-HMO Enrollees



Source: HCFA/Office of the Actuary; data from the Medicare Current Beneficiary Survey, 1993.

Beneficiary Attitudes Towards HMOs and Fee-for-Service, 1993

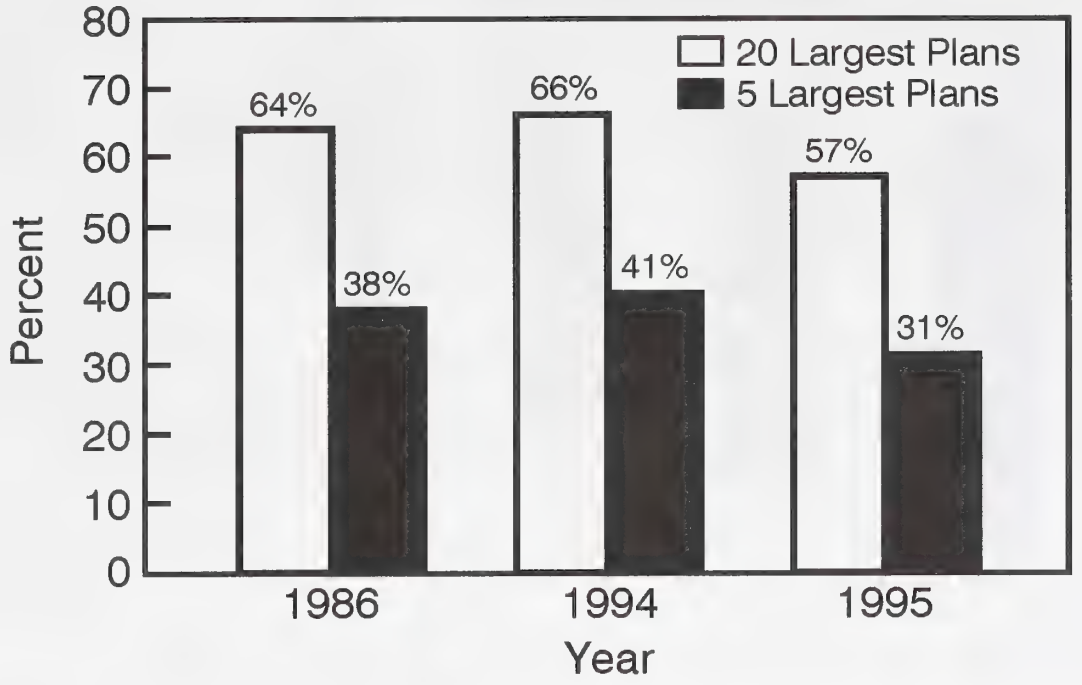
Risk HMO Enrollees Are Most Satisfied With HMO Costs



Source: HCFA/Office of the Actuary; data from the Medicare Current Beneficiary Survey, 1993.
Note: "Satisfied" includes very satisfied and statisfied; "Unsatisfied" includes unsatisfied and very unsatisfied beneficiaries.

Enrollment Concentration In The Largest Risk HMOs, 1986, 1994, 1995

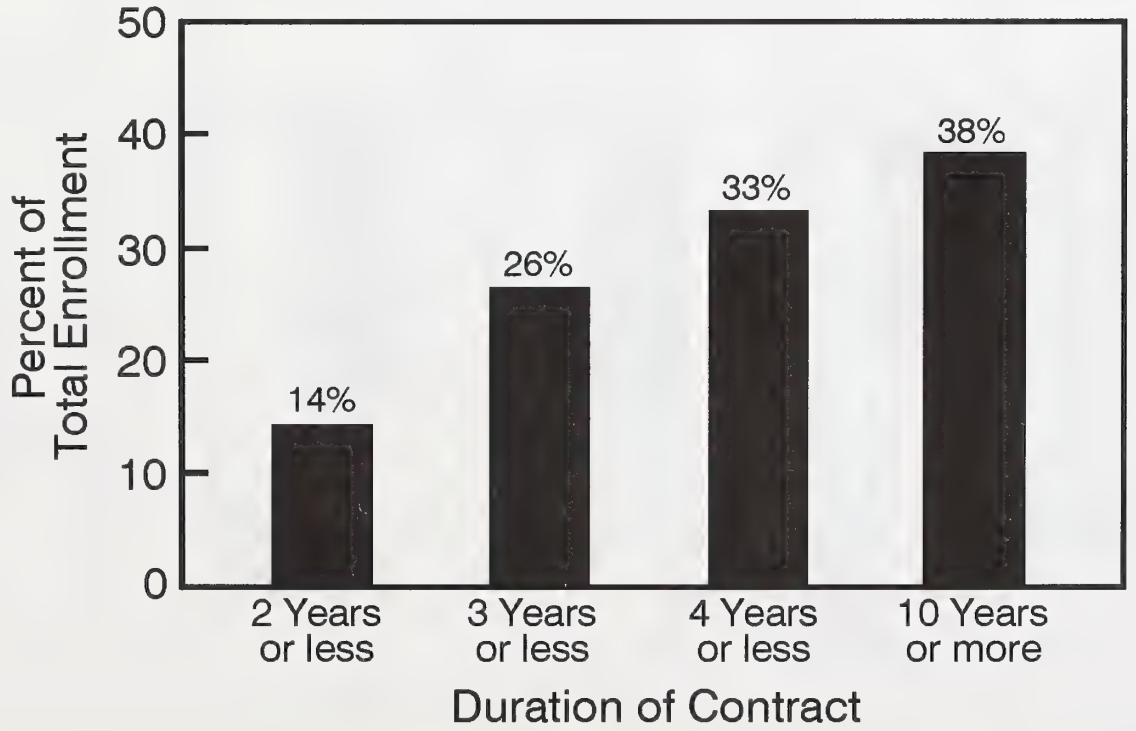
The Level Of Concentration In Larger Plans Is Declining



Source: HCFA/Special Analysis Staff Development of Office of Managed Care Data

Enrollment Distribution By Length Of Medicare Risk Contract, 1995*

New Plans Have A Significant Proportion Of The Enrollment, As Do The Oldest Plans



*As of December 1995
Source: HCFA/Special Analysis Staff Development of Office of Managed Care Data

Glossary

AAPCC

Adjusted Average Per Capita Cost. The basis of payment for Medicare risk HMOs, the AAPCC is a yearly projection of program expenditures in fee-for-service Medicare (i.e. beneficiaries not enrolled in HMOs). Medicare pays risk HMOs 95% of the AAPCC for each enrolled Medicare beneficiary, based on the beneficiary's county of residence, age, sex, Medicaid status, institutional status, and supplemental insurance status. ESRD is a separate statewide category.

Administrative Costs

Includes costs for marketing, enrollment, customer services, claims processing, and profits for for-profit entities.

Aged

As used here, those 65 years of age and older.

Ambulatory care sensitive condition

Medical condition that should not require hospitalization with appropriate ambulatory treatment, e.g., asthma or diabetes.

Ambulatory surgical center (ASC)

A facility that provides surgical services that do not require a hospital stay. Medicare pays for use of an ambulatory surgical center for certain approved surgical procedures. Medicare will also pay for physician and anesthesia services that are provided for the procedure.

Assigned claim

A claim for which the physician or supplier agrees to accept the amount approved by Medicare as the total payment. Medicare pays the physician or supplier 80% the Medicare approved amount. The doctor or supplier can charge the beneficiary only for the coinsurance, which is the remaining 20% of the approved amount. A *participating* physician or supplier agrees to accept assignment on all claims.

BDMS

Bureau of Data Management and Strategy. This HCFA component maintains data on beneficiary eligibility, and the utilization and cost of program benefits.

BPO

Bureau of Program Operations. This HCFA component is responsible for Medicare claims processing operations and related functions. Private insurance companies under contract to HCFA, known as carriers and intermediaries, process Medicare claims.

Competitive Medical Plan (CMP)

A managed care organization that is not a federally-qualified HMO but which meets Medicare statutory requirements for entering into a Medicare risk contract.

Cost-based HMO

An HMO which is paid by Medicare for the actual cost of providing care to Medicare enrollees. The term includes cost HMOs, cost CMPs and HCPPs.

Disabled

As used here, disabled individuals under 65 years of age. Disabled persons become eligible for Medicare when they have been receiving social security disability insurance benefits for 24 months. Individuals under 65 years of age diagnosed with end-stage renal disease are also eligible to receive Medicare benefits.

DHHS

U.S. Department of Health and Human Services.

Elderly

As used here, those 65 years and older.

End-stage renal disease (ESRD)

Irreversible kidney failure. To survive, the patient must either receive a kidney transplant or periodic kidney dialysis. Individuals with ESRD are eligible for Medicare benefits.

ESRD facility

A facility that provides renal dialysis services.

Federally-qualified HMOs

An HMO which meets Federal requirements for certification as a prepaid health plan that is able to offer a comprehensive range of services through a specified network of providers.

HCFA

The Health Care Financing Administration, an agency within the U.S. Department of Health and Human Services that administers the Medicare and Medicaid programs.

HCPP

Health care prepayment plan. A managed care organization that contracts with HCFA to enroll Medicare beneficiaries for coverage of some or all Medicare-covered physician and supplier services (Part B). HCPPs are paid on a reasonable cost basis.

Health Care Financing Review

A quarterly journal published by HCFA's Office of Research and Demonstrations (ORD).

Health professional shortage area

A geographic area determined by the U.S. Public Health Service to have a shortage of physicians or other health professionals.

HMO

Health Maintenance Organization. HMOs provide or arrange for a comprehensive package of health care services for a fixed monthly premium with nominal copayments permitted.

HMO penetration

The percentage of insured lives in a market area enrolled in HMOs.

Home health agency (HHA)

A public or private agency that specializes in giving skilled nursing services and other therapeutic services, such as physical therapy, in patients' homes.

Home health benefit

The portion of the Medicare program that pays for care to homebound beneficiaries. Care must provided by a home health agency which participates in the Medicare program. Covered services include part-time or intermittent skilled nursing care, physical and speech therapy, occupational therapy and part-time or intermittent services of a home health aide.

Hospice

A public agency or private organization that is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill people. Medicare beneficiaries may elect to receive hospice care instead of standard Medicare benefits for terminal illnesses.

Managed care plan

A general term applied to a wide range of insurance plans, including HMOs, where choice of providers is limited and administrative measures control utilization of services. The types of Medicare managed care plans include health maintenance organizations (HMOs), competitive medical plans (CMPs), and health care prepayment plans (HCPPs).

MCBS

Medicare Current Beneficiary Survey. A sample of Medicare beneficiaries are interviewed to collect information on demographic characteristics, health status and functioning, insurance coverage, financial resources and family supports. The beneficiaries are re-interviewed periodically to form a continuous profile of their health care experience.

Medicaid

A joint Federal-state program that provides medical assistance for those with low incomes. Medicaid is administered by the States and jointly funded by the States and the Federal government. It was authorized in 1965 by Title XIX of the Social Security Act.

Medicare Select

A HCFA demonstration project authorized in 15 states. Medicare Select are Medigap plans that limit coverage to services delivered through a specified network of providers. If a beneficiary uses a non-network provider other than for emergency services, the Medicare Select plan is not obligated to reimburse the beneficiary's incurred deductible or copayment. Medicare program payments are nevertheless made for both network and non-network services.

Medicare supplemental insurance or "Medigap"

Private insurance which supplements Medicare by paying Medicare deductibles and coinsurance. There are ten nationally standardized policies (plans A to J). Some policies offer coverage not provided by Medicare, such as coverage for outpatient prescription drugs and care outside the U.S. Also called Medigap Insurance.

NCHS

National Center for Health Statistics. The component of the U.S. Public Health Service which collects and maintains statistics on various aspects of public health.

Non-institutionalized

Individuals not living in facilities such as nursing homes.

Nursing home

A general term applied to skilled nursing facilities, and facilities providing custodial care.

OACT

Office of the Actuary. This HCFA component provides estimates of expenditures for the Medicare and Medicaid programs and of health expenditures in the U.S.

OBRA

Omnibus Budget and Reconciliation Act of a given year.

OLIGA

Office of Legislative and Inter-Governmental Affairs. This HCFA component coordinates Medicare and Medicaid legislative strategies and congressional hearings, and facilitates relationships with Congress and the States.

OIG

Office of the Inspector General. This component of the Department of Health and Human Services conducts evaluations to promote program effectiveness and investigations to detect fraud and abuse.

OMC

Office of Managed Care. This HCFA component administers the Medicare and Medicaid managed care programs.

ORD

Office of Research and Demonstrations. This is the HCFA component which conducts or sponsors research on health policy issues and conducts demonstrations of new health care delivery and payment mechanisms.

Participating physician/supplier

A physician or supplier who has agreed to accept assignment on all Medicare claims (see assignment).

Point of service (POS)

In reference to Medicare risk HMOs, a benefit option that permits enrollees to use non-network providers for which the HMO pays for a portion of the cost of care within limits determined by the HMO.

Risk HMO

An HMO that is paid a pre-determined per-member payment from Medicare to provide all necessary covered services to its Medicare enrollees.

Skilled care

Skilled nursing care or skilled rehabilitation services, such as physical therapy. Medicare pays for nursing home stays requiring daily skilled care for a condition related to a prior hospitalization. Medicare also pays for part-time or intermittent skilled care provided by a home health agency to those who are homebound.

SAS

Special Analysis Staff. This HCFA component conducts special studies and prepared this chartbook.

SNF

Skilled Nursing Facility. A facility which is certified by Medicare to provide skilled nursing or rehabilitation services.

Supplier

A firm which provides durable medical equipment (such as wheelchairs and oxygen equipment), prosthetic and orthotic devices (artificial limbs and braces), or medical supplies (such as surgical dressings).

USPCC

United States per capita cost. The national average expenditure per person incurred by the Medicare program.

Zero Premium HMOs

HMOs which offer Medicare beneficiaries services not covered by Medicare for no additional premiums and no copayments or deductibles.

Overview of Medicare

Medicare, authorized under title XVIII of the Social Security Act, is a nationwide health insurance program for the aged and certain disabled persons. It was first enacted by Congress in 1965, and consists of two parts:

Hospital Insurance (Part A)

- Individuals eligible for Social Security are automatically entitled when they reach age 65.
- Individuals under age 65 are eligible if they have been disabled for at least two years.
- Persons with end-stage renal disease are eligible for coverage.
- Individuals over age 65 who are not automatically entitled may enroll in Part A if they pay a monthly premium.
- Financed through payroll taxes on workers and their employers (FICA tax).
- Covers inpatient hospital, skilled nursing facility, home health, and hospice care.

Supplementary Medical Insurance (Part B)

- Voluntary.
- Enrollment open to individuals 65 or older, or those already entitled to Part A benefits.
- Financed through general revenues (about 75% of program costs) and enrollee premiums (about 25% of program costs).
- Covers physicians' and other outpatient medical services (and home health care for those without Part A).

MEDICARE COST SHARING 1996

•	Inpatient Hospital Deductible	=	$736	per benefit period
•	Part B Deductible	=	$100	per year
•	Part B Premium	=	$42.50	per month

- In addition, beneficiaries pay co-payments for SNF, extended hospital stays, and co-insurance for physician, durable medical equipment, supplier and hospital outpatient services.

OVERVIEW OF THE MEDICARE MANAGED CARE PROGRAM

The Basics of Medicare HMOs...

Health Maintenance Organizations (HMOs) and similar types of organized health care delivery systems have the option of contracting with HCFA to provide services to Medicare enrollees.

Medicare payment to HMOs is either on a risk or a cost basis. Risk HMOs are paid a pre-determined per-member payment to provide all necessary covered services to their Medicare enrollees. HCFA determines a risk HMO's monthly capitation payments based on yearly projections of Medicare program costs for non-HMO beneficiaries in a given county. An at-risk HMO receives 95% of the **"adjusted average per capita cost" (AAPCC)** for each of its members. The AAPCC varies by county, and also varies by demographic factors of individual enrollees (age, sex, Medicaid status, and other factors). At this time, HCFA does not have sufficient data to adjust the AAPCC based on an individual's health status.

As with non-Medicare enrollees of HMOs, in general, Medicare members of a risk HMO are "locked in" to the HMO for all Medicare-covered services, except in the event of an emergency. That is, care is covered as long as the member uses providers authorized by the HMO to provide care. However, under current law, Medicare HMO enrollees are free to disenroll from an HMO on a month-to-month basis (as contrasted with the typical year lock-in required by employer-sponsored HMOs among the working population).

Medicare risk HMOs may offer members a point-of-service option permitting reimbursement when members use non-network providers.

HMOs and similar organizations can also receive Medicare payment on a cost reimbursement basis. Medicare will pay the HMO the actual cost of providing care to Medicare enrollees. The HMO is not "at risk" in that event, and Medicare enrollees of such organizations are not "locked in" to the HMO for services. Medicare will continue to pay for "out-of-plan" services billed to Medicare's carriers and intermediaries.

Another option for HMOs in some States is to obtain fee-for-service reimbursement on behalf of enrollees of a Medigap plan that limits its Medigap coverage to in-plan services (Medicare Select).

The Adjusted Community Rate (ACR) Premium Approval Requirements

Medicare law provides that if a risk HMO's projected AAPCC payments in a given year are expected to exceed the costs of providing care to the organization's Medicare enrollees (including any profit of a for-profit entity), the HMO must either accept a reduced payment or return the savings to Medicare enrollees in the form of reduced out-of-pocket expenditures (premiums and copayments) and/or in the form of additional benefits not otherwise covered by Medicare.

In some areas of the country, HMOs also "waive," or decline to collect, cost-sharing amounts from Medicare enrollees. For Medicare-covered services, HMOs may collect from their enrollees the equivalent of Medicare's fee-for-service coinsurance and deductibles (e.g., the hospital deductible or coinsurance on physician services). The AAPCC payment from HCFA includes only actual program expenditures, not beneficiary liability amounts.

Because of the return of savings provisions, and because of the practice of waiving otherwise collectible amounts, beneficiaries in many HMOs have little or no out-of-pocket expenses and have relatively rich benefit packages--including coverage of prescription drugs. This is particularly true in high AAPCC areas, such as Miami and Los Angeles, where HMOs can operate at costs well below regional fee-for-service levels of cost.

Prior to the beginning of each contract year, HCFA reviews rate proposals and benefit packages proposed by each risk HMO. This **adjusted community rate or ACR** process determines whether an HMO will be in a position of having to return savings to its Medicare enrollees. As part of the ACR process, HMOs also advise HCFA as to whether premiums or other cost sharing will be waived.

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